

***Strategy and Planning Framework
for the Integrated Package of
Maternal, Neonatal and
Child Health Services 2009-2015***

**Taking Urgent and Concrete Action for Maternal, Neonatal and
Child Mortality Reduction in Lao PDR**

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Foreword

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Abbreviations

ANC	Antenatal Care
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
C-IMCI	Community IMCI
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
HMIS	Health Management Information System
IFC	Individuals, Families and Communities
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ITN	Insecticide Treated Nets
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Agency
LRHS	Lao Reproductive Health Survey
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
MSM	Men having Sex with Men
NGO	Non-Governmental Organization
NSEDP	Lao National Social-Economic Development Plan
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PNC	Post Natal Care
REACH	Ending Child Hunger and Undernutrition
SBA	Skilled Birth Attendant
SIA	Supplementary Immunization Activity
TBA	Traditional Birth Attendant
TWG	Technical Working Group
U5MR	Under-5 Mortality Rate
UNFPA	United Nations Fund for Population Actions
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

1. Introduction

The purpose of this document is to present a Strategy and Planning Framework for the implementation of the Integrated Maternal, Neonatal and Child Health Package in Lao PDR until 2015. The document outlines a unified strategy and planning framework, to guide stakeholders in designing, implementing and evaluating maternal, neonatal, child health, immunization and nutrition programs under stronger government leadership.

The Government of Lao PDR is committed to graduating from the list of least developed countries by 2020 and to achieving the Millennium Development Goals (MDGs) by 2015. To fulfil these commitments, the Lao National Social-Economic Development Plan (NSEDPlan) (2005-2010) and the Sixth Five-Year Health Sector Development Plan (2006-2010) have defined clear targets for health, including reducing maternal mortality to 330 per 100 000 live births and under-five mortality to 75 per 1000 live births.

The priority areas of work and strategic approaches described in the document are aligned with overall policies and strategies of Lao PDR and will be implemented by the Ministry of Health with support, when requested, of its Development Partners.

Based on primary care values, the MNCH strategy and planning framework describes health system strengthening and mobilizing individuals, families and communities to achieve **rapid and equitable scale-up** for delivery of essential, cost-effective, evidence based interventions to improve maternal, neonatal and child health. This document will be the basis for the initial phase of the MNCH package implementation in selected districts, its evaluation and for developing district health plans to progressively scale-up maternal, neonatal and child health through integrated delivery of key interventions.

2. Situation analysis

2.1. Socio-demographic situation

The Lao PDR is a landlocked country situated in the center of Indo-China and surrounded by Kingdom of Thailand, Kingdom of Cambodia, Vietnam, China and Myanmar. This mainly rural country is home to 5.6 million people (Census 2005), the majority of whom are under 15 years of age. The population is divided throughout 17 provinces, many of which are difficult to access due to the highly mountainous landscape. Laos has been identified as having 49 officially recognized ethnic groups divided into four main linguistic groups with different cultures, traditions, and livelihood systems. These ethnic, cultural and language diversities heavily influence health seeking behaviors and practices and present a challenge for health service delivery.

Lao PDR has progressed significantly in the past two decades since introducing its economic reforms, with improvements in health and primary education outcomes. Despite this Laos remains one of the poorest countries in East Asia with some of the worst social outcomes. Laos is ranked amongst the bottom quarter of countries (135/177) on the UNDP Human Development Index (2006) and approximately 30% of the population continues to live below the poverty line, with considerable differences between provinces, regional, urban and rural settings. There are significant gender disparities in access to health care and education. Men are more literate than women, 83 compared with 63 percent, with important differences between provinces and ethnic groups (Census 2005).

Table 1: Socio-economic and health indicators

Indicator		Source	Year
Gross National Income per Capita (USD)	\$500	World Bank	2007
Households without electricity	40%	LRHS	2005
Household with no toilet	50%	LRHS	2005
Population using improved drinking water source	40%	WHO/UNICEF	2008
Adult literacy rate	73%	Census	2005
School enrolment	Girls 68% Boys 75%	Census	2005

2.2. Progress towards National Targets and MDGs

Among 68 countries included in Countdown 2015, Laos is one of 21 countries on track to achieve MDG 4, but unlikely to achieve MDG 5 and MDG 1.

Table 2: Demographic health indicators

Indicators	1990	1995	2000	2005	Source of data	Targets 2015
Crude Birth Rate per 1000 population	45	41.3	36.3	34.7	NSC Census 1995 & 2005, and LRHS 2000	-
Total number of births	185,940	188,948	191,369	195,083		-
Infant Mortality Rate per 1000 live births	134	104	82.2	70		45
Maternal Mortality Ratio per 100 000 live births		656	530	405		260
Under 5 Mortality Rate per 1000 live births	170	170	107	97.6		55
Neonatal Mortality Ratio per 1000 live births	59.0	45.8	36.2	30.8		-

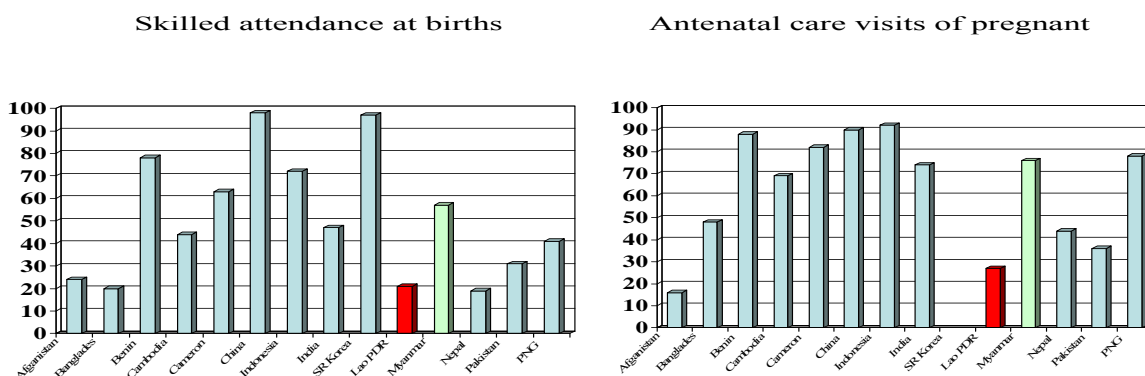
2.2.1. Maternal Mortality

The maternal mortality ratio (MMR) in Laos remains among the highest in East and South East Asia at 405/100 000 live births which means that approximately 800 mothers die per year or 2 deaths per day. The routine MNCH reporting system of the MCH centre in 2006 documented that only 51 hospital maternal deaths were recorded suggesting that more than 90% of mothers died at home without access to health services. The vast majority of maternal deaths and disabilities could be prevented through appropriate reproductive health services before, during and after pregnancy, and through life-saving interventions should complications arise. In Lao PDR coverage and quality of these services is low.

2.2.1.1. Assistance at birth

Measuring MMR accurately is difficult therefore the proportion of births attended by skilled birth attendants (SBA) is used as a proxy measure to monitor the progress towards the MDG 5 target of reducing maternal mortality. The majority of Lao women (84.8%) give birth at home (LRHS 2005). Births assisted by health providers only marginally increased from 17.4% to 18.5% between 2000 and 2005 (LRHS 2005), lagging far behind the average of 57% of developing countries around the world. The LRHS 2005 showed that 63.4% of births were assisted by family members or relatives, 12.1% by traditional birth attendants and 3.4% gave birth alone. Disparities between urban and rural settings are marked; 51% of the urban population delivered at health facilities whereas most of the rural population delivered at home (87% of rural with road and 96.5% of rural without road) (LRHS2005).

Figure 1.



Source: Lancet 2005 and Lao MIC III

The LRHS 2005 found that the majority of women (75.7%) not giving birth in a hospital thought it was “not necessary”. Other reasons included cost of hospital delivery, low quality of the service provided at health facilities nearby (health centre and some districts), presence of a male health worker in health centre, cultural influences and geographical distance. The high percentage of women who give birth without skilled health personnel (doctor, nurse, and midwife) is of concern as attendance at delivery by skilled health personnel and emergency obstetric care are key interventions that can substantially reduce maternal and perinatal mortality and disability.

2.2.1.2. Access to Emergency Obstetric and Neonatal Care (EmONC)

Fifteen per cent of births are estimated to have complications requiring medical care and women with a post partum haemorrhage may die within two hours if they do not receive skilled medical care. The Census 2005 showed that 24.6% of the Lao population lives more than 2 hours from a fully functioning EmONC hospital. Even women who live closer to facilities may not have access to EmONC because many hospitals at present cannot provide a full range of emergency obstetric and neonatal care services. The Assessment of Skilled Birth Attendance in Lao PDR 2008 showed that only 27 of the 41 comprehensive EmONC facilities and 5 of 107 basic EmONC facilities (district hospitals) were able to provide all the required EmONC functions. If the existing facilities and staff skills were upgraded, 87.4% of the population would be within 2 hours travel time of a fully functioning EmONC hospital (Laos Census data).

An international minimum standard of Caesarean section rate required for maternal and newborn health is 5%. In Laos the national Caesarean section rate is 2%, with several provinces as low as 0.2 - 0.3% indicating that a large proportion of women and infants are not receiving emergency care for complications. Although no data exists, because of the very low rate of assisted delivery, obstetric fistula is likely to be a problem in Laos especially in rural areas.

2.2.1.3. Antenatal and postnatal care

Antenatal care (ANC) can help women to identify potential risks and plan for a safe delivery. It also serves as an entry point into the health care system. In Lao PDR only 28.5% women received ANC and this proportion was lower among women with less education and rural, older and high-birth order women (LRHS 2005). Of those receiving ANC, 60.7% of women undertook 4 or more visits and only 10.9% of women obtained their first ANC during the first trimester of pregnancy. More than three quarters (76.4%) of women did not take iron tablets (93.7% of women in rural without road) and only 5.9% of mothers took 90 tablets or more (0.7% of women in rural without road).

Postnatal care (PNC) for the mother and the newborn baby is recommended in the early postpartum period. The recommendation is for a routine check-up within the first week of life and as a minimum follow-up at 6 weeks after birth. The purpose of postnatal visits is to ensure women receive appropriate care and support after childbirth for themselves and their baby and to reduce maternal and neonatal mortality, morbidity and disability due to complications arising in the postnatal period (WHO 2005). In Lao PDR postnatal care is provided only around six weeks after birth and coverage is estimated to be low.

2.2.1.4. Family planning

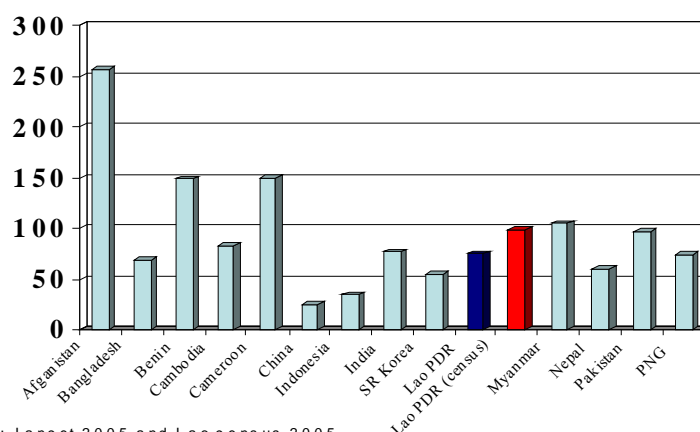
Family planning is said to contribute to reducing maternal deaths by up to 30% by eliminating high risk and unwanted pregnancies. Contraceptive prevalence rate (CPR) increased from 29 to 35% among married women between 2000 and 2005, but unmet need still remains high at 27% (LRHS 2005). The CPR is higher in urban than rural women in Laos and women living in rural areas with better access (urban 44.7%, rural with road 36% and rural without road is 25.6%).

If no urgent and intensified efforts to increase access to family planning, antenatal care and especially skilled care at birth are put in place, Lao PDR will not achieve the MMR target of 330 by 2010 as in the National Social-Economic Development Plan, or 260 by 2015 to achieve the MDGs.

2.2.2. Neonatal, Infant and Child Mortality

According to National Census 2005, the Infant Mortality Rate is 70 per 1000 live births and the under-5 mortality rate is 98 per 1000 live births which are both high by regional standards. This equates to approximately 19,600 Laotian children dying before their fifth birthday or 36 deaths per day.

Figure 2.
Under five mortality rate (2005)

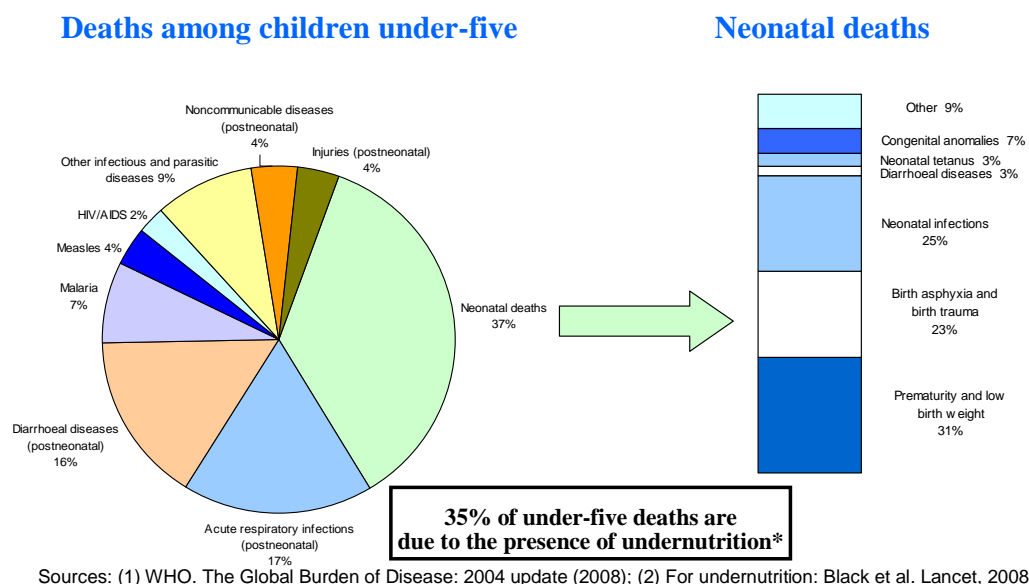


Source: Lancet 2005 and Lao census 2005

Cause specific mortality data is not available for Lao PDR but WHO modeling estimates that deaths are due to common preventable and treatable conditions including pneumonia, diarrhoea and perinatal conditions.

Figure 3.

Major causes of death in neonates and children under-five in the world - 2004



Neonatal deaths (deaths during the first 4 weeks of life), account for more than 1/3 under of five child deaths and more than ½ of infant deaths in Laos. Evidence suggests that the majority of neonatal deaths occur within the first week of life and in Lao PDR this would equal 74% of neonatal deaths in the first week (WHO 2005). Although infant mortality is decreasing in Laos, there has been a slowing of reduction of neonatal mortality suggesting that skilled birth attendance and neonatal interventions should be given priority.

2.2.2.1 Immunization

In 2000, according to UNICEF/WHO official estimates only 42% of children received immunization against measles and this coverage has declined even further to 40% in 2007. The current coverage of the other antigens is also low DPT3 50%, and Polio3 46% in 2007 and the percentage of children who have received all eight recommended vaccinations by their first birthday is 27%. In Lao PDR, 55.5% of women are protected against neonatal tetanus (MICS 2006) but the protection at birth figure has declined in 2007 to only 52%. While some uncertainty exists on the number of births used as denominator, these declines have been attributed to financial shortfalls in operational costs both for outreach and supervision, and vaccine stock-outs.

Due to the extremely low routine immunization coverage it has been necessary to conduct supplementary immunization activities (SIA) in 2007 and 2008. First there was a highly successful national measles SIA that vaccinated more than 2,000,000 children aged 9 months to 15 years achieving 96% coverage. This should give an effective coverage of 81.6% when sero-conversion failures are accounted for and keep the country free from outbreaks for the next 2-3 years. Sub-national immunization days for polio protection were conducted in December 2008 and continued in February/March 2009. There also is a plan to conduct large

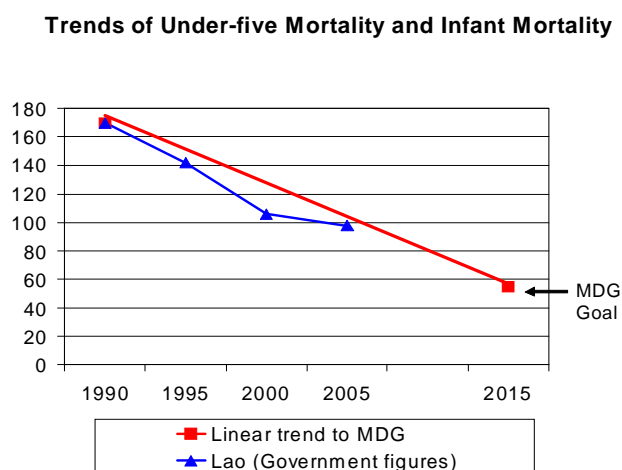
scale tetanus toxoid SIA targeting 1,000,000 child bearing age women for maternal and neonatal tetanus elimination in 2009 and 2010.

2.2.2.2 IMCI and child care interventions

The integrated management of childhood illness (IMCI) is an evidence based cost-effective strategy to deliver key preventive and curative neonatal and child health interventions. Lao PDR began IMCI implementation in 2002 but coverage is incomplete, the quality of implementation is variable and technical updates are necessary to improve delivery of child health interventions. The MICS survey 2006 showed that care for illnesses could be further improved; in cases of diarrhoea 50.5% of children were given oral rehydration (ORT) therapy, and 49.2% received ORT or increased fluids, and continued feeding. Care seeking for suspected pneumonia was 32.3%, but only 52.1% of children with suspected pneumonia received antibiotic treatment. While 86.7% children under-five sleep under a mosquito net, only 40.5% sleep under insecticide-treated nets. In 2008, key IMCI stakeholders from Laos were introduced to the IMCI Computerized Adaptation and Training Tool (ICATT) which will assist in the incorporation of new recommendations into existing national guidelines and for computer based training.

Lao PDR is on track to reach the target of the National Social-Economic Development Plan, and to achieve MDG4 if current trends continue.

Figure 4.



Nevertheless, the under-five mortality rate in Lao PDR is still unacceptably high. The current progress may slow down or stagnate because of poor coverage of key child health interventions, including immunization and neonatal interventions.

Source: UNICEF MICS database and MOH Lao

2.2.3. Maternal and Child Malnutrition

Poor nutritional status of women including the prevalence of chronic anaemia contributes to maternal morbidity and mortality. In Lao PDR, according to the 2006 Nutritional Survey data, 14.5% of women of childbearing age have a Body Mass Index (BMI) <18.5, and 14.3 % have a BMI >25, while 36.2% of women of childbearing age have mild or severe anemia, of which iron deficiency anemia is 14.6% (based on plasma ferritin levels) and 19.5% (based on plasma transferrin levels). Only 5.9 % of women have received iron and folate supplementation for more than 90 days during pregnancy.

The prevalence of underweight children under five years of age has remained unchanged between 1990 (40%) and 2006 (37.1%). In 2006, the prevalence of stunting and wasting of under-fives were 40.4% and 6.5% respectively. There has been a significant reduction in wasting both among urban and rural children over the past five years, indicating positive reversal of acute malnutrition. Despite this there has been no progress in reduction of under-weight and stunted children reflecting chronic under-nutrition.

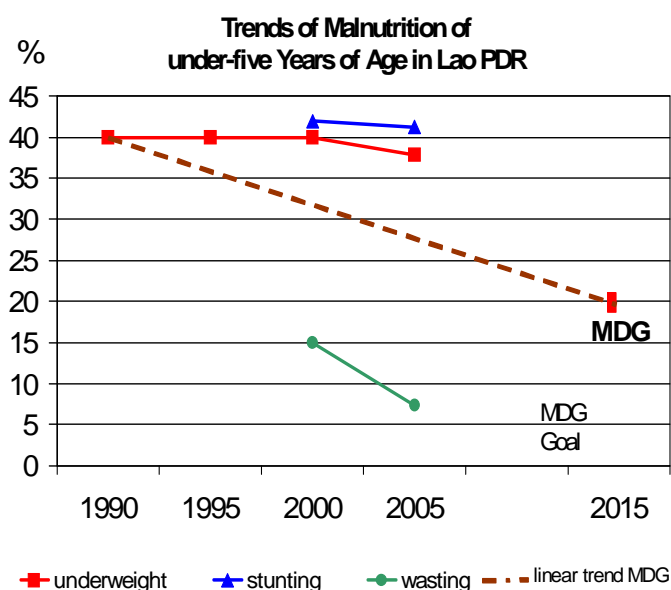
Low rates of exclusive breastfeeding and low intake of energy and nutrient rich complementary food is the major cause of malnutrition in children under five years of age and a common factor that may cause

disability. The MICS 2006 found that 26.4% of children less than 6 months of age are exclusively breastfed and 29.8% of women breastfed their babies within one hour of birth. At age 6-9 months 70.4% of children are receiving soft/mushy, semi solid or solid foods.

Micronutrient deficiency is a significant additional factor in child mortality with Vitamin A, iron, iodine and zinc being the most important for health, growth, development and a functioning immune system. In the 6 months prior to the MICS survey, 18.1% of children aged 6-59 months received a high dose Vitamin A supplement and 17.9% of mothers received Vitamin A within eight weeks of birth (MICS 2006).

Lao PDR is likely to fail in reaching the target of reducing malnourished children to 30% by 2010 (NSDP target) and to halve the 1990 level (MDG target).

Figure 5.



2.2.4 HIV/AIDS

Although the country estimates HIV prevalence is approximatively 0.2% (age 15-49 years old), HIV prevalence is higher among Sex-workers (0.6%) and men having sex with men MSM (5.6%). According to 3rd round of sentinel surveillance and specific surveys there are potential factors that may increase the spread of HIV such as rapid development and migration among others. Lao PDR has a cumulative number of 1,523 reported AIDS cases and an estimated 8,000 people living with HIV, 50% of whom are between the ages of 20-39 and 1,331 adolescent girls and women aged 15 or more infected with HIV.

Young women and adolescent girls remain at particular risk to HIV infection. Typically they are unaware of the risks and unable to protect or negotiate safer sex to protect themselves. In 2005 a National Reproductive Health Survey noted that 79.2% of interviewed young women and adolescent girls knew about condoms as a contraceptive method, but only 3.6% ever used one. At 15, 10 % of ever married women had given birth and before the age of 18 approximately 37% of women had had one child. Knowledge levels about sexually transmitted infections and HIV/AIDS remains low in this age group and 69.4% of young women (15-19) as opposed to 82.9% of their male peers report ever having heard about HIV/AIDS. Female sex workers (84% of whom are between the ages of 15-24) while reporting 95% consistent condom use with clients, report 66% consistent condom use with 'casual' partners and a high percentage (32%) of condom

breakage. Invariably some young women and adolescent girls will transmit HIV to their unborn or new born infants.

There is a steady increase in reported cases of HIV infection in children. In 2007 the number of children reported to be infected with HIV was 20 with 10 reported cases of HIV infection in children under the age of 5. Approximately 79 children nationally are presently accessing anti-retroviral treatment. However, the actual number of children infected by HIV could be much higher if the actual number of women at child-bearing age and their additional vulnerability for both social and biological reasons are taken in consideration. For example, 41% of married men in a study conducted in Vientiane Capital reported having had sex with a sex worker during their wives pregnancy. The commonly held belief that sex during pregnancy increases the risk of miscarriage or damage to the unborn child has traditionally legitimized men's visits to sex workers when wives are menstruating or pregnant. While good progress has been made to prevent mother to child transmission of HIV, few women will ever access these services in antenatal clinics. Regrettably, the use of antenatal care by pregnant women is low and the greater majority of children will be born at home attended to by a family member or traditional birth attendant.

2.3. Current Actions for Maternal, Neonatal and Child Health

The health of mothers and children in Lao PDR is the responsibility of the Department of Hygiene and Disease Prevention, Ministry of Health. The Department of Hygiene and Disease Prevention also includes the National Immunization Programme and Nutrition Programme. At national level, the Mother and Child Health Centre is responsible for implementing programmes and coordinating the nationwide provision of maternal and child health services. The centre has a number of specialized programmes including reproductive health and safe motherhood, family planning, breastfeeding promotion, immunization and IMCI. All aspects of hospital care for mothers and children are the responsibility of the Department of Curative, MOH. Other MOH departments such as Department of Personnel and Food and Drug Department contribute to the delivery of MNCH services.

The MOH is assisted by partner activities from WHO, UNICEF, UNFPA, Luxembourg Development, JICA, World Bank, Asian Development Bank and Save the Children-Australia and benefits from global initiatives such as Global Fund, GAVI and REACH amongst others.

In 2007 a MCH-EPI Technical Working Group has been established by the MOH, as one of the components of the sector-wide coordination mechanism in health sector, to assist in developing an integrated package of MNCH services and the key strategies for its national expansion to reach high coverage by 2015. Meetings have been held once a month chaired by the deputy director of the Department of Prevention and Hygiene getting participation from relevant departments and institutions of the MOH and development partners.

2.4. Constraints to achieving the MDGs

Insufficient Health System Capacity: Lao PDR faces a wide range of obstacles in reaching MNCH related national socio-economic targets and achieving the MDGs. The health system has had insufficient capacity to deliver key maternal, neonatal and child health interventions. There has been lack of clear management policies and regulations and limited MNCH programmatic coordination and planning. There has been insufficient investment in health and the health workforce and lack of accurate data for decision making. The existing workforce is inadequately skilled, supervised, deployed, and also to a large extent lacks motivation. Access to health services is limited but even for those with access, because of poor quality of care and prohibitive out-of-pocket costs, there is under utilization of health facilities.

Fragmented Responsibilities: Vertical disease control programmes have achieved important gains but are not always well coordinated within mainstream health service delivery at health facilities. This is particularly the case when preventive and curative interventions could or should be delivered to the same individual at the same time but disease specific programme financing, staff training and reporting often circumvents this.

Additionally, fragmentation in partner support for national health programmes to deliver key interventions, plus the need for additional administrative and reporting mechanisms by partners exacerbates the negative situation. Up to recent time there has been lack of consensus on common objectives and insufficient communication and cooperation among partners thus resulting in sporadic interventions and training project by project.

Lack of investment and out-of pocket expenses: The proportion of gross domestic product spent on health in Lao PDR is 0.4% (about US\$1.5 per capita per annum). This is amongst the lowest in the region. Due to poor investment in health care, salaries for health workers are unacceptably low and the budget provided to health facilities is insufficient to cover all expenses required for service provision. Of the government budget, about 35% is devoted to hospitals nevertheless estimates from 2004 suggest that the government budget covers only 17-25% of recurrent costs at central hospitals and 32-85% at district hospitals. To overcome the gap, public health facilities rely on revolving drug fund mechanisms where each item sold is topped up by the legally allowed amount of 25% of the purchase price. This approach drives an incentive to sell drugs and medical items in as high quantities as possible. In the absence of any social health protection mechanisms that ensure wide population coverage, patients are exposed to unnecessary expensive diagnostic procedures and treatments. Out-of-pocket expenditure by sick people or their caretakers for treatment is thus a major cause of impoverishment and a deterrent to care. The government is in the process of reviewing the situation through the introduction of social health protection mechanisms including:

social health insurance for formal sector employees and their families

health equity funds –third party mechanisms whereby the health care costs for the poor are paid to the public health providers

community-based health insurance for the non-poor informal sector households

Despite this, expansion of these schemes is slow and their success depends on increased government financial support either to the health sector to improve quality of care or to the scheme operators to purchase quality services and to cover the costs for the poorest.

Availability and quality of services: Mother and child health services are available in most health facilities through out the country but there is a lack of consistency in both the number of available services and quality. Surveys indicate that due to poor organization of care, opportunities for providing the full set of recommended MNCH interventions are often missed. In most district hospitals, the majority of MNCH interventions are available, although only 5% of district B facilities can perform BEmONC. All provincial hospitals can provide complete services for mothers and children on a regular basis but the Assessment of Skilled Birth Attendance in Lao PDR 2008 revealed that the skills competency score of providers ranged from 51-84% with the exception of active management of the third stage of labor which was only 22%. Immunization is reported to be available in all villages nationwide, with outreach services organized at least four times per year but immunization coverage rates does not reflect this. Poor quality of care provided at health facilities and in communities at outreach, with irregular and mediocre service provision, is a major barrier preventing women and children from accessing health services. However on the positive side, management of pneumonia in children by community health care workers is implemented in the whole country, community based distribution for family planning is being successfully piloted in three southern provinces and maternity waiting homes are available in all districts in the southern provinces.

Access and utilization of services: There is inadequate access and under-utilization of MNCH services in Lao PDR at this time. Even if existing facilities and staff skills were upgraded, for some districts where the population is more dispersed, health services will remain too far for access. A total of 37 districts have around 25% of the population living greater than 2 hours from a hospital and in 18 districts about 50% of the population lives greater than 2 hours from a hospital (Lao census 2005). Difficulties linked to limited infrastructure and communication in rural and mountainous areas poses a challenge to provide quality care to part of the population, particularly in the raining season.

Studies in Laos have suggested that local traditions may prevent women presenting to health facilities at the onset of labour. Lao women also feel uncomfortable being seen by male health workers. There are difficulties for ethnic groups in accessing health services where often Lao language is the only language

spoken and cultural differences are poorly managed. The Maternity Waiting Homes introduced in selected districts have increased the number of institutional births and offered an opportunity to conduct health promotion activities for families living far from the health facility.

Human resources constraints: In the WHO Report 2006, Laos is one of 57 countries in the world with a critical shortage of health personnel (MOH 2007). Laos also experiences inadequate numbers of health providers who can provide skilled birth attendance (Human Resource for health analysis, Lao PDR 2007). Existing staff are poorly distributed with staff allocation highly concentrated in urban rather than in rural facilities. In 2005, 39% of new recruitments were placed at central level. In the past few years, net increase in the workforce has been below 2%, which is below the population growth rate and implies that the national ratio of health workers per capita has fallen. The majority of staff working in health facilities fall into the category of low-level cadre, and this is particularly marked at district level. Provinces that allocate more and higher-level staff to district level have better health outcomes. There is an increase in student enrolment in health care education, while very few jobs are created for them. Existing health workers also lack necessary skills to provide quality care for mothers and children. Additionally, health workers do not reach expected productivity. The number of births assisted by staff per year is considerably low and number of services provided by each health worker is relatively low. To respond to these challenges, the MOH has endorsed in November 2008 the SBA Development Plan. The challenge remains to ensure financial and technical support for its smooth implementation.

2.5. Individuals, Families and Communities

2.5.1. Knowledge and practices at household level

The behaviour of mothers and other care givers and decision-makers at home and in the community are the key to improving the health of women and children. Current coverage of interventions including antenatal care, skilled birth attendance, postnatal care, care seeking behaviour for disease, particularly for ARI, diarrhoea and fever and uptake of preventive interventions including immunization, Vitamin A and family planning suggests poor community knowledge for maternal and child survival interventions **and disability prevention** (MICS 2006, LRHS 2005). There have been a number of health promotion activities for maternal and child health in Lao PDR, but these have been fragmented and there has been no attempt for scaling-up.

A qualitative study using a participatory approach in Northern provinces in ethnic groups showed that certain nutrition behaviours, including food taboos, may contribute to the high prevalence of child malnutrition and micronutrient deficiencies. The study also found that many of these including barriers to exclusive breastfeeding, food taboos and hygiene behaviour may be amenable to change through relatively low-cost nutrition promotion (Holmes 2007). A further study in urban Laos assessing traditional practices showed the existence of restricted postpartum diets and inadequate maternal nutritional intake, but concluded that antenatal care offered an opportunity to address postpartum nutrition (Barennes 2007).

2.5.2. Participation of communities

A number of community structures exist in Lao PDR that may be accessed for the provision of health services. These include the Local Commission of Women and Children, Lao Women's Union and Lao Youth Union, village health committees, village health workers and village health volunteers. Together with village leaders and traditional birth attendants (TBA), these stakeholders may be engaged to deliver community maternal, neonatal and child health interventions, including health education on nutrition, hygiene, clean water and sanitation, and promoting birth and emergency preparedness planning, facility birth and care seeking for sick children and pregnant women.

2.6. Summary of key MNCH Issues, Gaps and Priorities

ISSUES that should be addressed in maternal, neonatal and child health in Lao PDR through implementation of the MNCH strategy and plan of action include high mortality and morbidity indicators and health system constraints.

Mortality and Morbidity Indicators: Lao PDR has high maternal, neonatal, infant and child mortality rates, low rate of exclusive breastfeeding, high prevalence of anaemia in women of childbearing age, high prevalence of iron deficiency anaemia and a high malnutrition and stunting prevalence. Though data is lacking there is likely to be significantly high case fatality rate and disability rate for specific diseases including malnutrition, measles, pneumonia, diarrhoea and malaria in children under-five and a high institutional maternal mortality due to obstetric complications.

Health system constraints: The health system in its current form is unable to adequately support maternal, neonatal and child health. There is a very low proportion of births attended by a skilled birth attendant and of births taking place in a facility. There is insufficient coverage of basic emergency obstetric and newborn care, family planning, antenatal care and postnatal care. Policies on routine post partum care are lacking and health financing and data collection is inadequate. Through improved immunization coverage for tetanus and Hepatitis B and if national syphilis screening and treatment were available, morbidity caused by these conditions could be improved.

Significant GAPS exist in achieving improved health outcomes for maternal, neonatal and child health in 3 areas.

Leadership, governance and management: Gaps exist in availability of national standards, protocols and guidelines, implementation of government policies and guidelines and MCH staff capacity for program management particularly at provincial and district levels. There is weak capacity in data collection, analysis and reporting and a weak birth and death registration system particularly for stillbirths and neonatal deaths. There is poor coordination between and within sectors in supporting maternal, neonatal, child and nutrition activities and health financing constraints including conformity in user fees, per diem and incentive systems.

Health service provision: Health service delivery is compromised through lack of skilled birth attendant numbers and limited capacity of existing health care providers. Health facility organization has significant gaps with insufficient availability of basic emergency and comprehensive obstetric and neonatal care, referral problems and missed opportunities for service delivery. There are logistic problems with lack of availability of drugs, supplies and equipment at facility level and weak capacity to conduct integrated outreach services. There is also limited capacity for investigation of deaths particularly neonatal and infant deaths. Existing services are of poor quality with limited protocols and lack of support for scaling-up existing programs including IMCI.

Individuals, families and communities: Gaps exist in implementing community based maternal, neonatal and child health activities through lack of a clear communication strategy, poor linkages and communication between health facilities and the community, limited community mobilization and participation, lack of coordination at provincial and district level as well as a lack of empowerment and capacity of individual, families and communities to demand services.

To improve maternal, neonatal and child health outcomes, PRIORITIES should be addressed in the areas of: Leadership, governance and management: National standards, protocols and guidelines should be defined for implementing the MNCH package and existing guidelines, including IMCI, should be updated. Standards should be used as the basis on which to improve MCH staff capacity to manage and supervise quality health service implementation. The Human Resource Development Policy currently being drafted needs to be finalised and implemented as quickly as possible for proper production, recruitment, deployment and retention of the workforce. A team to champion the implementation of the integrated package should be established at provincial and district level and equipped with necessary management and supervision skills. Process indicators in all aspects of MNCH need definition and assessing progress will require assistance in monitoring against key indicators. An approach to improving data collection and management for MNCH and notification system for births, deaths and disability should be introduced. A system to support the investigation of maternal, neonatal and child deaths should be established at national and provincial levels. Mechanisms to address health financing issues for MNCH are required as a matter of urgency.

Health service provision: Skilled birth attendants are the cornerstone of improved MNCH services and the SBA training plan should be disseminated and implemented. Training institutions will require strengthening

and existing training curriculum for nurses and doctors revised to ensure all aspects of the integrated MNCH are included particularly basic and comprehensive emergency obstetric and neonatal care. In-service training should be conducted particularly in the neglected areas of antenatal and postnatal care and family planning and existing training programs including IMCI should be scaled up. Monitoring and supervision of all aspects of program implementation is necessary to improve quality of MNCH care and support in reporting on key indicators is required. Drugs supplies and equipment, minimal standards for health facility functioning and the referral system will require strengthening to implement improved MNCH services. As many women are from geographically isolated areas, a plan for expanding Maternity Waiting Homes should be developed to promote facility delivery.

Individuals, families and communities: Health promotion and community participation must be introduced to increase the demand for MNCH services. This will require strong advocacy and a national health promotion strategy for MNCH. Existing IEC materials should be reviewed and appropriate materials developed. Community leaders and groups should be consulted and engaged to support and participate in the implementation of maternal, neonatal and child health promotion activities, **including addressing disability**. Training plans should be developed that include active participation of individuals, families and communities. TBAs and Village Health Volunteers will need training in health education and promotion for key messages for maternal, newborn and child health. In addition specific activities have been recommended in the *National SBA Plan* for assisting existing TBA to refocus their role, improve supervision and linkages between SBA and TBA and to assist those TBAs with at least minimum of grade 8 schooling to undertake further study to assist them gain entry into Community Midwifery programme and in some places support them to set up an accredited out-of facility practice back in their own community, which is linked to and part of the Health system.

A list of key issues, gaps and priorities, according to three main areas: a) leadership and governance, b) health service provision, and c) individuals, families and communities is provided in Annex 2.

3. The MNCH integrated package of care and delivery mechanism

3.1 Health Policy Environment

The Government of Lao PDR is committed to achieving the targets of the National Social-Economic Development Plan and the MDGs. To enable these developments, the National and Provincial Committee for Mother and Children (NPMC) have been established under the leadership of the Standing Deputy Prime Minister at the national level, and vice-governor at the provincial and district levels. Laws, policies and plans relevant to maternal, neonatal and child health include:

National Growth and Poverty Eradication Strategy 2006-2010
National Social-Economic Development Plan 2006-2010
Sixth Five-Year Health Sector Development Plan 2006-2010
Lao Health Master Plan 2005
National Reproductive Health Policy, MOH 2005
Regulation on the Promotion of Maternal and Child Health, MOH 2004
Women Development and Protection Law 2004
National Intestinal Helminth Prevention and Control Policies 2003
Hygiene, Prevention and Health Promotion Law 2002
Primary Health Care Policy, MOH 2000
National Population and Development Policy (NPDP) 1999
Prime Minister's Decree-Establishment of the National Commission for Mother and Child 1999
National Code of Breast Milk Substitutes, adopted 2007
National Breastfeeding Policy MOH
Baby Friendly Hospital Initiative
National Nutrition Policy, 2008
National Policy on HIV-AIDS control, MOH 2000
National PMCT Protocols
National Strategic Action Plan on HIV/AIDS/STI 2006-2010
National SBA Plan 2008-15

3.2. An essential package of MNCH care

An essential package of MNCH evidence-based interventions has been defined by the MCH/EPI Technical Working Group. The package includes priority interventions that, if implemented at high coverage, will have substantial impact on maternal, neonatal and child mortality reduction and maternal and child malnutrition and disability prevalence.

Table 3. MNCH Integrated Package and Delivery Channels to provide MNCH Care

O: Essential services

Δ: Optional services

	Item of services	Community Resources	Outreach Services	Health Centre	District Hospital		Central & Provincial Hospital
					B	A	
Non-pregnancy RH care	Health information and counselling	O	O	O	O	O	O
	Weekly Iron and folate supplementation	O	Δ	Δ	Δ	Δ	Δ
	Condoms and oral contraceptives	O	O	O	O	O	O
	FP injectable		Δ	O	O	O	O
	IUD			Δ	O	O	O
	Vasectomy, tubal ligation				Δ	O	O
Pregnancy care – at least 4 routine antenatal care visits	Monitoring progress of pregnancy and assessment of maternal and fetal well being		Δ	O	O	O	O
	Detection & management of pregnancy problems (e.g. anaemia, hypertensive disorders, bleeding, mal-presentation, multiple pregnancies)			O	O	O	O
	Iron & folate supplementation	O	O	O	O	O	O
	Two doses of TT immunization or at least three in the past		O	O	O	O	O
	Use of insecticide-treated bed nets from prenatal to postnatal	O	O	O	O	O	O
	De-worming	O	O	O	O	O	O
	STI/HIV risk assessment, counselling and referral		Δ	O	O	O	O
	Syphilis testing*			O	O	O	O
	Information and counselling on self care at home, nutrition, sexual activities, breastfeeding, family planning, healthy lifestyle	O	O	O	O	O	O
	Mobilization for choosing health facility as preferred place for birth, birth to be attended by SBA even for out of facility births, birth and emergency preparedness planning including, advice on danger signs	O	O	O	O	O	O
	Back up antenatal care if complications				Δ	O	O
	Post-abortion care and treatment of abortion complications				Δ	O	O
Intrapartum care	First level intrapartum care including partograph, AMTSL ¹ , injectable antibiotics, oxytocin, magnesium sulphate, insertion of IV and neonatal resuscitation			O	O	O	O
	Back up EmONC including above plus vacuum extraction, manual removal of placenta, manual vacuum aspiration				O	O	O
	Back up/comprehensive EmONC including above all functions plus Caesarean Section, blood transfusion					O	O

¹ AMTSL: active management of the third stage of labour

* When Rapid Test available

	Item of services	Community Resource	Outreach Services	Health Centre	District Hospital B	A	Central & Provincial Hospital
Newborn care	Immediate newborn care (thermal protection, cord care, assess breathing, initiation of exclusive breastfeeding, infection prevention, eye prophylaxis)	Δ	Δ	O	O	O	O
	Neonatal resuscitation		Δ	O	O	O	O
	Information and counselling on home care, breastfeeding, hygiene, advice on danger signs, emergency referral and follow-up	O	O	O	O	O	O
	Immunization according to the national guidelines (BCG, HepB)			O	O	O	O
	Special newborn care if complications or high risk conditions (sepsis, severe asphyxia, preterm birth, malformation, etc.)				Δ	O	O
Postnatal care	Information and counselling on home care, self care and nutrition, breastfeeding, hygiene, FP, advice on danger signs, emergency referral and follow-up	O	O	O	O	O	O
	Routine postpartum maternal care (within 7 days and up to 6 weeks)		Δ	O	O	O	O
	Iron & folate supplementation	O	O	O	O	O	O
	Vitamin A supplementation	O	O	O	O	O	O
	Postnatal newborn care (within 7 days)	Δ	Δ	O	O	O	O
Child health care	Promotion of breastfeeding and complementary feeding	O	O	O	O	O	O
	Micronutrient supplementation	O	O	O	O	O	O
	Routine immunization of the child		O	O	O	O	O
	TT+2 immunization to women of reproductive age to protect neonatal tetanus		O	O	O	O	O
	Outpatient care of the sick child (IMCI)		Δ	O	O	O	O
	Hospital care of the sick child (IMCI)				O	O	O
	Community IMCI	O					
	Use of insecticide-treated bed nets	O	O	O	O	O	O
	De-worming	O	O	O	O	O	O

Refer to WHO Recommended Interventions for Improving Maternal and Newborn Health (WHO/MPS/0705), and WHO/UNICEF Regional Child Survival Strategy (2006)

3.3. Guiding Principles

3.3.1. Convention of Elimination of All Forms of Discrimination Against Women (CEDAW) and Convention on the Rights of the Child (CRC)

The CEDAW was ratified by Lao PDR in 1981. The CEDAW provides the basis for realizing equality between women and men through ensuring women's equal access and opportunities in political and public life including health and education. CEDAW is the only human rights treaty which affirms the reproductive rights of women. The CRC and its monitoring body the United Nations Committee on the Rights of the Child provides a valuable framework for child health. Laos ratified the CRC in 1991. Both Conventions provide a foundation for improving maternal, neonatal and child health.

3.3.2. Equity

To reduce inequities in Lao PDR, MNCH interventions must reach the poorest and most marginalized households. This includes those marginalized by geographical, social, political, economic, and ethnic and gender factors. The majority of Laos households have a low income therefore achieving universal coverage of the integrated package of MNCH interventions by strengthening the primary health care network is the most appropriate approach to reducing inequities. This approach should be complemented by wider social protection schemes and targeted forms of outreach to vulnerable and excluded groups. If pro-poor approaches are used, they need to be implemented at high coverage to be most successful.

3.3.3. Building on scientific evidence and international consensus

National adoption of existing international recommendations as documented in WHO Recommended Interventions for Improving Maternal and Newborn Health (WHO/MPS/0705) and WHO UNICEF Regional Child Survival Strategy.

3.3.4. Building on existing national policies

Determinants of maternal, neonatal and child survival that are beyond the scope of the health sector, in particular water, sanitation and the environment, physical access to services, gender equity, female empowerment and female education are addressed through other national policies and strategies. This strategy is built on existing Lao PDR national policies and strategies.

3.3.5. Integrated Approach

The MNCH interventions should be viewed as being implemented together not as individual elements, as part of a person-centred response to the health needs of the woman and the child and delivered along the continuum of care. The package brings together promotive, preventive and curative interventions that are mutually beneficial and inextricably linked to the goals of reducing maternal, neonatal and child mortality and the prevalence of malnutrition in children. Health service delivery must be organised in a way to use synergies at every delivery point and to reduce transaction costs. The goal will be to create primary care teams organized in functioning district primary care networks able to offer coordinated and comprehensive MNCH services to the communities they serve.

4. Strategy Overview

The Integrated Maternal, Neonatal and Child (MNCH) Mortality Reduction Strategy in Lao PDR will address goals of the Sixth Lao National Social-Economic Development Plan (NSED) (2005-2010), the Sixth Five-Year Health Sector Development Plan (2006-2010) of the Government of Lao PDR and *Millennium Development Goals* including reducing maternal, infant and child mortality rates and improving the nutritional status of women and children. The MNCH Strategy also follows the NSED which emphasizes the importance of health in the development of the country and in the final aim of poverty eradication with service delivery at the centre of its agenda. The MNCH Strategy will be the guiding document for maternal, neonatal and child health in the Seventh Lao National Social-Economic Development Plan (2011-2015) and the Seventh Five-Year Health Sector Development Plan (2011-2015).

4.1. Vision

Implementing the Integrated Maternal, Neonatal and Child Mortality Reduction Strategy in Lao PDR will achieve universal coverage of an essential package of interventions for all mothers and children in Lao PDR regardless of gender, geographical, socio-economic and ethnic differences in a health system based on primary health care.

4.2. Mission Statement

The Government of Lao PDR is committed to maternal, neonatal and child health and will create primary care networks in which all players of the health sector and communities contribute to their full potential to the national goal of reducing maternal, neonatal and child mortality and to the reduction in maternal and child malnutrition.

4.3. Goal

To reduce the maternal, neonatal and child mortality and maternal and child malnutrition in Lao PDR

Reduce the Maternal Mortality Rate to 260 per 100 000 live births by 2015 (MDG5)

Reduce the under-five Mortality Rate to 55 per 1000 live births by 2015 (MDG4)

Reduce the Infant Mortality Rate to 45 per 1000 live births by 2015 (MDG4)

Reduce the Neonatal Mortality Rate to 24 per 1000 live births by 2015

Reduce prevalence of malnourished under-five children by one quarter between 2005 and 2015 (MDG1)

To reduce anaemia in women of reproductive age from 37% to 25% by 2015

4.4. Strategic Objectives for Maternal, Neonatal and Child Mortality Reduction

The strategy comprises three strategic objectives:

Improving leadership, governance and management capacity for programme implementation

Strengthening efficiency and quality of health service provision

Mobilizing individuals, families and communities for maternal, neonatal and child health

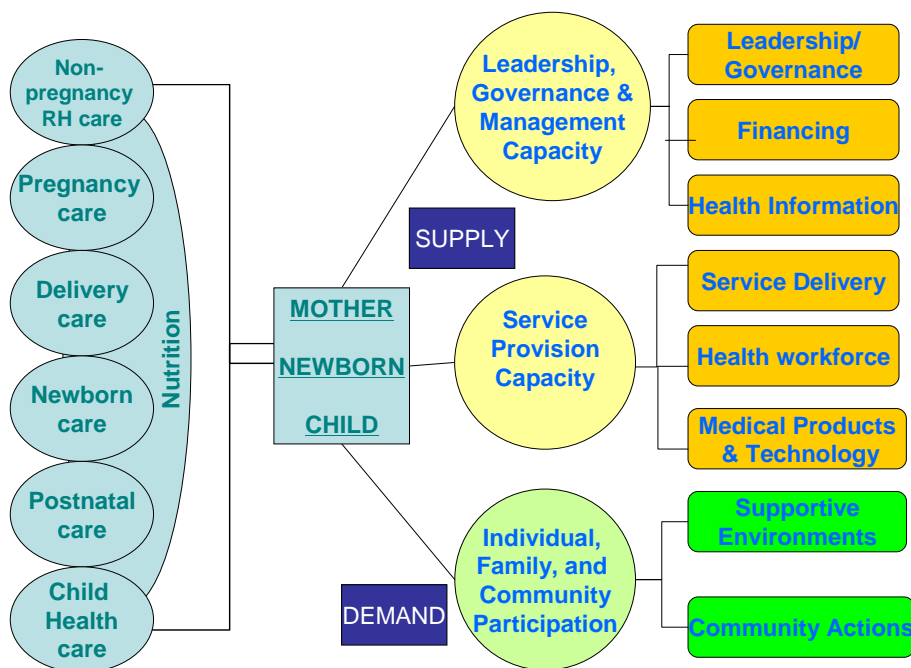
Strategic objectives one and two for Maternal, Neonatal and Child Mortality Reduction are based on the six building blocks articulated in the "Strategic Plan for Strengthening Health Systems in the Western Pacific Region, WHO 2008". The six building blocks predominantly address SUPPLY.

Six Building Blocks for Health System Strengthening

1. Financing
2. Health workforce
3. Information
4. Medical products and technology
5. Service delivery
6. Leadership/governance

The third strategic objective addresses the DEMAND side through considering the importance of creating a supportive environment whereby individuals, families and communities can have a voice in their own health and through community participation. These can be viewed as additional building blocks on which the strategy is based. Delivering the MNCH Package is presented in a framework according to the lifecycle of the mother, newborn and child, the 3 strategic objectives and the building blocks.

Figure 6. Framework for the implementation of the MNCH integrated package



5. Strategy for Maternal, Neonatal and Child Mortality Reduction

The strategy is articulated around three strategic objectives and 8 main strategies.

5.1. Strategic Objective 1: Improving leadership, governance and management capacity for programme implementation

5.1.1 Strengthening leadership and governance for MNCH

Accountability and good governance

Strengthening leadership and management structures within MOH is necessary to ensure progress in maternal, neonatal and child mortality reduction. MOH must lead this process and ensure sector coordination and partner consolidation to accelerate necessary action. There may be a need for changes in policy, laws and regulations which will require clear guidance across all relevant sectors. Ensuring that responsibilities are assumed and acted upon will require good governance and involvement of non-government institutions and community-based organizations.

High-level coordination mechanisms already exist and these will be strengthened to facilitate ongoing planning and effective implementation of the Integrated Package of maternal, neonatal and child health services. A MCH/EPI Technical Working Group is already operational and coordination with other TWGs must be improved. The Health Sector Working Group will ensure coordination and collaboration with other sectors to seek additional support and leverage of resources and will report action taken to the National Commission of Mother and Child. This approach will promote improved coordination between various Ministry of Health departments, such as Hygiene and Disease Prevention, Curative, Cabinet Office, Planning and Finance and Organization and Personnel, the Maternal and Child Health Centre and the Centre for HIV/AIDS and STI (CHAS), but also with all relevant stakeholders from other governmental sectors including finance, planning and investment, education, agriculture and legislation.

To ensure that all government and donor efforts are synchronised, the Strategy and National Plan should be endorsed as the definitive approach for all stakeholders working to improve maternal, neonatal and child health in Lao PDR. One budgeted plan (using a mutually agreed costing tool), one coordination mechanism and one monitoring and evaluation process will ensure maximum impact of improvement efforts. All MNCH activities by governments and partners should adopt one common training plan and support a community participation approach. Such an approach is in line with the Vientiane Declaration 2006 which called for greater aid effectiveness in Laos.

Policy formulation

Implementing the Integrated MNCH Package to scale dictates the need for policy formulation in several areas including:

National standards setting: National standards, protocols and guidelines should be developed or revised based on internationally accepted evidence based documents as outlined in WHO/UNICEF/UNFPA publications. Standards will be defined in a Manual of Operation Procedures that will ensure quality. There is a need for MOH to define a process for ensuring that defined standards are enforced and regularly reviewed and updated as necessary to improve quality of care for mothers and children.

Regulatory mechanisms for service providers and facilities, including maternity waiting homes and the private sector

Human resources: performance incentives for fixed site service delivery, per diem for outreach, including for attending out of facility births, and supervision

Health financing: update regulation/removal of user fees, safety nets for vulnerable groups

5.1.2. Develop financing mechanisms for increasing access to MNCH services

No consensus amongst Lao policymakers has been reached regarding the choice of financing strategies to enable access to MNCH curative and preventive care. However, increased government budget allocation to health is indispensable for success in improving access to MNCH services in Lao PDR. Means to increase government spending for health include raising the country's tax revenue base, improving the MOH capacity to lobby for increasing budget allocation to health and the forthcoming revenue from hydropower projects. Potential mechanisms to reduce financial barriers to access MNCH care in Lao PDR include social protection schemes (health insurance, social safety nets), conditional cash transfers, in addition to lowering or removing user fees. These mechanisms are not mutually exclusive and can be used in combination, depending on the available financial resources.

Removal or lowering of user fees for MNCH services will improve their financial accessibility but hidden costs must be considered, including loss of income for women and other caretakers when accessing care for themselves or their children and transport costs to the site of service delivery. Since health care providers in Laos overtly depend on revolving drug fund mechanisms to finance their services, abolishment of user fees without providing compensation to the providers may not improve access because services will be unavailable as facilities cannot purchase consumables or under-the-table payments will continue. One key option is to decide whether funding for MNCH services should be channelled through the supply- (regular government budget, district grant allocations, performance fund (subsidies) or through the demand-side (health equity funds, maternity waiting homes, health insurance schemes).

Health insurance has the potential to purchase quality services on behalf of the insured but the current extent of coverage is too small to have any significant impact. Since health insurance is especially a means to avert impoverishing health expenditures, the emphasis of such schemes is on curative care. To be really beneficial for promoting the uptake of MNCH services they should be explicitly included in the benefit package.

Health Equity Funds (HEF) pay for health services (and sometimes hidden costs) on behalf of a defined group (e.g. those identified as poor, or those living in targeted geographic areas), typically based on external financing. In some parts of the country it is possible to consider channelling the funding of part or the entire MNCH service package through HEF. This mechanism may have operational advantages and can help funding agencies reduce fiduciary risk. However, the administrative overhead costs are significant, often greater than 30%.

Conditional cash transfers originate from Latin America and are now widely used elsewhere whereby regular monetary transfers are provided to the poor on the condition that they comply with a pre-defined set of social behaviours. For MNCH interventions in Laos such cash transfers could be linked to uptake of a range of preventive services such as antenatal care, assisted deliveries, initiation of breastfeeding and immunization of mothers and infants. When cash transfers are provided for uptake of preventive services it is imperative to ensure that these services are effectively available, with good quality and provided at minimal costs for the concerned poor.

Increased budget availability must go together with improved efficiency including increased output per health worker, using locally appropriate cost-effective interventions and moving away from financing mechanisms that foster excessive diagnostic and treatment practices such as the revolving drug funds at secondary and tertiary facilities.

5.1.3. Improve Health Information for better planning, monitoring and evaluation of MNCH and related services

Data is required for decision making in implementing the integrated MNCH strategy. There should be a move towards registration of all births and deaths so that impact indicators can be more readily assessed without the need for large population surveys. To monitor programme implementation at district level, progress should be measured by monitoring process indicators. Staff providing service delivery should be

those collecting and analysing the data and using this information to change MNCH services provision as necessary. National Programme data collection forms should be harmonized so that there is one data collection form (paper or electronic) for MNCH activities to ease data collection and provide ready comparison over time and between facilities. The Laos MOH Health Management Information System (HMIS) Strategic Plan is underway using Health Metric Network methodology and MNCH data processes should be linked to this tool. Health facility staff will require skills in using the HMIS and basic data collection, analysis and use for improving programme management.

Mortality audit and case review processes should be developed for maternal, neonatal and child deaths. This can be commenced in hospitals with a simple standardized system and monthly mortality meetings whereby staff are involved in reviewing deaths and complicate cases. This process may assist to circumvent preventable deaths in the future as staff may participate in the solution through a quality improvement process. In time MNCH mortality audit processes at community level including verbal autopsy could be introduced.

5.2. Strategic Objective 2: Strengthening efficiency and quality of health service provision

5.2.1. Strengthening the delivery of MNCH services

Facility-based service delivery

Facility-based service delivery for a comprehensive range of integrated preventive and curative interventions should be the basis of service delivery in the long term. Fixed-site service offers an economic and logistic advantage of delivery of more maternal and child interventions in an integrated way. All levels of health facilities and all staff members should provide the complete package of MNCH interventions as defined for that level of facility (health centre, district hospitals B or A, provincial and central hospitals). Special attention should be paid to ensure closer to people care, by strengthening the capacity of health centres and district hospitals to provide the full range of MNCH interventions. Staff at health facilities should optimize contact points to deliver more interventions to mothers and children. A visit for an infant's immunization may offer an opportunity for counseling on infant and young child feeding, maternal nutrition and reinforcing contraceptive advice. It is recommended that staff should check client's cards, such as immunization, growth monitoring, ANC and FP cards whenever the woman or child comes to a facility. Mothers should be encouraged to bring these cards by being informed that they can receive different services at the same visit when the card is presented. Performance based incentives for staff providing fixed site delivery of interventions may require consideration to deter outreach <5 km from the health facility and for other services. This could be by providing a results based allowance to individuals (e.g. increased number of births) or results based increased budget to facilities (reaching required outputs), or giving high identity and opportunity for training and professional development.

A good referral system must be ensured with reliable means of communication by radio or mobile phones and reliable transport for emergencies, complications and for difficult cases. Financing mechanisms for transport need to be arranged. Pre-referral treatment should be provided as per guidelines.

In addition to the continuing expansion of Hepatitis B immunization, the MOH is planning to introduce new life-saving vaccines: first, *Haemophilus influenza type B* in 2009, then in subsequent years, pneumococcal, rotavirus and Japanese encephalitis vaccines depending on funding. These vaccines will have a significant impact on child mortality and morbidity and will also decrease the health facilities work load and costs.

Outreach

MOH should develop a clear outreach policy defining when outreach is appropriate, who should provide outreach and to where and appropriate per diem. Outreach activities should be planned to respond to the need of remote communities and to ensure that preventive services and health education messages reach high coverage. A package of interventions has been defined for outreach which includes immunization, deworming, Vitamin A supplementation and health promotion particularly for nutrition. In remote areas,

outreach particularly for immunization services remains the only way to deliver a limited number of key additional interventions.

Care at birth provided by skilled birth attendant will be needed for those women who can not or who, as yet have not been persuaded to come to facility for birth. This may be dealt with separately to a more formal outreach with scheduling of visits to a village or community. Community visits by skilled birth attendants to mothers and babies after delivery and the postpartum period will be required for those mothers giving birth at home. It is suggested that a visit is planned within 3 days of delivery and at 6 weeks postpartum. Not only will this identify immediate difficulties but will provide opportunities for the delivery of other interventions. These visits can be part of the formal outreach programme.

Quality improvement

Quality improvement approaches will lead to improved quality of maternal, neonatal and child care. Improving quality of care for MNCH should be based on attaining national defined standards of care. Health workers should be trained in the use of evidence based standard treatment guidelines for mothers and children and adhere to these guidelines at all levels of health facilities. Good quality hospital care is required to increase the impact of appropriate primary care interventions and referral on maternal, neonatal and child survival. Certification of facilities which can meet the minimum standards should be introduced. MNCH health workers once they have received appropriate MNCH training and found to be proficient could be eligible for certification.

5.2.2. Develop sufficient and skilled health workforce for the provision of MNCH integrated services

Human resources competent to implement the MNCH package must be ensured at all levels of the health system. Criteria should be developed to ensure priority for training and where needed deployment to more densely populated districts, as well as health facilities and communities located at not easy reach from a referral hospital. Primary care providers' role should be strengthened and their capacity to respond to the health needs of a defined population should be improved.

The MOH, with support from UNFPA and WHO, has recently launched the Skilled Birth Attendance Development Plan 2008-2012 which provides a detailed roadmap to identify and address gaps in human resources for maternal and neonatal health. This plan should be implemented but gaps for delivery of child survival interventions particularly in the districts should also be addressed. The Government of Lao PDR is currently developing the Human Resources for Health Strategy where health sector wide human resource development approaches will be described including those for MNCH. Key MNCH staff at central, provincial and district level will require strengthened capacity for management and supervision of MNCH services.

Training of existing workforce, including skilled birth attendants, to improve MNCH practices particularly at primary care level will be provided by short clinical based modules. Five core modules including basic emergency obstetric and neonatal life saving skills (compulsory foundation module), antenatal care and postnatal care, essential newborn care, family planning and IMCI (including neonatal extension) will be available and with exception of the foundation module can be taken in any sequence over a period of time or all together. With intensive efforts and coordinated planning it is hoped that this training will be reach all services points at the first level of care (HC and Hospital type B). Additionally an internship module, specific for labour and birth (intra-partum) care will be used for hospital staff training.

Encouraging supportive supervision with immediate feedback and appropriate follow-up improves performance in the short term and if correctly done can assist in professional development, job satisfaction and increasing motivation of health workers. On-the-job training, coaching and mentoring where health workers receive continuous support and feedback on a regular basis will also lead to performance gains. If feasible regular facility visits by external supervisors will assist in self-monitoring of the facility and health worker individual performance.

Medical and nursing schools curricula should be strengthened to provide pre-service education in the integrated MNCH package. Training materials already exist for components of the MNCH package and can be readily incorporated through review of existing curricula. Attention must be given for adequate focus on

practical skills during training including emergency obstetric and neonatal life saving skills and contraception methods and ensuring students can identify opportunities for integration at service delivery contact points. Professional development for faculty members will be necessary to ensure that they are familiar with the integrated approach for MNCH services as well as to upgrade their own skills and capacities. Formal training for MCH staff (doctors, nurses, and midwives) should be developed as these cadres would have an important role in continuous education, supervision and mentoring.

5.2.3. Improve the management of Medical Products and Technology for MNCH services

An adequately constructed health facility with functional amenities, including water and sanitation, and essential drugs, supplies and equipment are necessary for effective delivery of the MNCH package. Standard checklists and systems of medicines, vaccines and commodities for family planning, maternal services, neonatal care, IMCI, Paediatric hospital care services and health promotion materials should be developed for each level of health facility. Health facilities must have standardized procurement mechanisms and disbursement mechanisms so that materials are ordered and delivered in a timely fashion. Wastage of medicines, materials and vaccines should be minimised. Medical equipment management systems under development in Laos would assist in improving MNCH services.

5.3. Strategic Objective 3: Mobilizing individuals, families and communities for maternal, neonatal and child health

Community action for maternal, neonatal and child health is dependent on a demand and a supply component. Families and communities should be empowered to demand appropriate health interventions and appropriate quality of care through a strategy for involving individuals, families and communities. Many families do not know what standard care to expect from health service providers and what practices are unnecessary or harmful. The MOH and other stakeholders must be committed to working with individuals, families and communities and should facilitate the establishment of primary-care teams with clear responsibility for the delivery of the integrated MNCH package to defined populations.

A behaviour change communication (BCC) strategy using health education/ health empowerment approach should be developed and include the Key Community IMCI Family Practices which targets messages for mothers and babies. Locally adapted key health messages for Essential Care in Pregnancy, Childbirth Postnatal and Newborn care are also required including maternal and neonatal danger signs, implementation of a birth and emergency preparedness plan and transport in case of emergency , which also require involvement of the local community. The BCC strategy should use different channels, including mass media and inter-personal communication, have clearly defined target audiences, provide training and capacity building, ensure partner coordination and information sharing and create a critical mass for stimulating peer pressure for appropriate health behaviours. Health education and promotion materials developed through existing and previous MNCH projects in Lao PDR should be reviewed, lessons learned should be extracted and successes replicated.

Community participation techniques, when truly participatory in nature, allow individuals, families and communities (IFC) more ownership in not only identifying priorities in MNCH, but also finding local solutions and contributing to planning and monitoring of services to ensure services do meet their needs and expectations. Primary care health workers will require training in community participation and health promotion techniques to work effectively with IFC. Health facilities' staff, through outreach activities and fostering community involvement in the planning, implementation and monitoring of health promotion and health care activities will lead to sustainable changes in family and community practices. Health workers should identify and use the range of existing structures and individuals in the community to participate in the planning and delivery of MNCH interventions at community level. This will strengthen coordination mechanisms at grassroots level.

The roles and responsibilities of community health volunteers and TBAs where they exist and are known to be functioning should be clearly defined and Government and partners should support the training of IFC in improved knowledge and communication skills for maternal, neonatal and child health. An IFC curriculum should clearly identify the Key C-IMCI Family Practices and maternal practices to be promoted and how to achieve this. The baby friendly hospital initiative (BFHI) and baby friendly community initiative (BFCI) that

focus on IYCF activities should also be supported as skills in promoting IYCF at community level may similarly be used to improve other family and community practices. Women in the community can be trained to provide peer support to pregnant women in birth preparedness, accessing skilled birth attendance and for young mothers in relation to IYCF activities and other activities. The code for marketing of breast milk substitutes was adopted in 1995 and should be enforced so that harmful commercial pressure on families is limited.

Community based distributors have been used to deliver FP in villages in Lao PDR. Community based individuals and groups could also be trained to distribute a limited number of drugs and commodities such as iron tablets, ORS, contraceptives, ITN and soap particularly in hard to reach areas. Well supervised village health workers may have a role in antibiotic treatment of ARI in hard to reach areas.

TBAs can be registered locally so they are easier to support and supervise. TBAs can also be helped to train as a Community Midwife, if they have adequate minimal schooling and are willing to undertake further studies. Local initiatives with the education sector or local NGOs may be utilized to help provide the additional vocational general education needed for entry into the Community Midwife programme. When they are qualified these new Community Midwives can be supported to establish accredited practices back in their home place that are linked into the formal service delivery network. Those TBAs that can not be trained as a community midwives can be assisted to refocus their role as community birth supporter, to work with and assist SBA for out-of facility births, as well as accompany women and stay with in the health facility during labour and birth or become a community volunteer MNCH worker. No more TBAs will be trained to be a TBA. However on-the-job training in the key messages and supportive supervision will be required for all existing TBAs until they cease operating as a TBA or re-trained as appropriate.

6. Strategic objectives, key strategies, expected results and activities

Strategic Objective 1: Improving leadership, governance and management capacity for programme implementation

Strategy 1.1 Strengthen leadership and governance for MNCH

Expected Result 1.1.1

One coordination mechanism, one national plan and one monitoring and evaluation process is established for all stakeholders working on maternal, neonatal and child health in Lao PDR and coordination is strengthened at all levels of the health system

Activities

- A national mechanism is established to coordinate ongoing planning for implementation of the Integrated Package of Maternal, Neonatal and Child Health Services based on the strategy document
- The strategy is accepted by all stakeholders as the definitive budgeted plan for maternal, neonatal and child health in Lao PDR
- The monitoring and evaluation framework is accepted and adhered to by all stakeholders
- MNCH Technical working group review progress quarterly and reports to the Health Sector Working Group and National Commission of Mother and Child
- Regular meetings are held with TWGs on Planning and Financing, on Human Resources for Health and on Nutrition

Expected Result 1.1.2

Policies are developed and national standards, protocols and guidelines for the MNCH integrated package are defined and disseminated

Activities

- Develop and approve a policy and guidelines of supervision of health workers at all health facilities and for outreach and community midwives in private practice in the community
- Develop and approve a policy and guidelines on performance incentives for fixed site intervention delivery
- Develop and approve a policy and guidelines for outreach including per diem and incentives for out-of-facility births by SBA
- Develop and approve a policy and guidelines for weekly iron and folate supplementation in WRA
- Develop and approve a national strategy and plan on Maternity Waiting Homes
- Develop national strategy for deployment of maternal, neonatal and child health workforce in districts according to need
- Finalise the Manual of Operation Procedures for MNCH services
- Disseminate the Manual of Operation Procedures
- Update clinical protocols and guidelines for integrated MNCH services as needed
- Disseminate clinical protocols and guidelines for integrated MNCH services
- Develop policy/regulation on SBA practices to include scope of midwifery practice, and licensing and re-licensing of SBA
- Develop policy for accreditation of facilities which meet the minimum standards
- Update Mother and Child Handbook
- Develop a policy and guidelines on prevention, detection and early intervention for disabilities

Expected Result 1.1.3

MNCH staff capacity on management and supervision of health MNCH services is strengthened at central, provincial and district level

Activities

- Orient staff on the MNCH package, requirements, roles and responsibilities
- Train key central, provincial and district level health personnel in a package of: methods of management and supervision, utilization of national standards, protocols and guidelines, situation analysis (including data analysis and dissemination), definition of priority interventions, monitoring, evaluation methods, report writing and basic computer software package (Excel and Word)
- Develop standard monitoring and supervision tools including administrative and technical components for maternal, neonatal and child health
- Undertake 4 integrated monitoring and supervision visits to each level of health facility per year
- Ensure supervision visits to each level of health facility by specific program (immunization, safe motherhood, IMCI, nutrition) once per year
- Ensure feedback from each monitoring visit

Expected Result 1.1.4

A well defined team for the implementation of the integrated MNCH package is established at provincial and district level

Activities

- Develop Terms of Reference for teams and appoint members
- Provincial health department to convene annual meeting with all districts to ensure integrated MNCH package is incorporated in budgeted annual operational plans for districts
- Ensure annual operational plans include budget for monitoring and supervision
- Ensure provincial health department harmonises all district plans to reflect integrated MNCH package
- Conduct quarterly meetings at all levels to review service provision and findings of monitoring and supervision using quality improvement methodology

Expected Result 1.1.5

A national committee on maternal neonatal and child deaths is created and functions regularly

Activities

- Develop Terms of Reference for national committee on maternal neonatal and child deaths, including child with disability deaths
- Appoint committee members and convene first meeting
- Develop support structure for provincial and district committees
- Work with central hospitals and statistics department of MOH to develop methods of reviewing maternal, neonatal and child deaths, including child with disability deaths

Expected Result 1.1.6

Provincial and district committees on maternal neonatal and child deaths are established and supported

Activities

- Develop Terms of Reference for provincial and district committee on maternal neonatal and child deaths, including child with disability deaths
- Orientate and create capacity at provincial and district levels to report and investigate maternal, neonatal and child deaths and to use data for improving MNCH service provision
- Conduct biannual meetings at provincial level to discuss district, health facility and community data

Strategy 1.2 Develop financing mechanisms for increasing access to MNCH services

Expected Result 1.2.1

The forthcoming Health Financing Strategy includes financing modalities to increase the provision of MNCH services

Activities

- Develop a uniform per diem and incentive system for public health staff members for effective MNCH service delivery with staff remuneration linked to performance
- Develop mechanisms to reduce inefficiencies in management of the health services in general
- Develop alternative finance mechanisms to the revolving drug funds at secondary and tertiary level that reduce use and prescription of unnecessary tests and drugs and promote delivery of essential MNCH services

Expected Result 1.2.2

The forthcoming Health Financing Strategy includes financing mechanisms to increase utilisation of MNCH services

Activities

- Develop mechanisms to reduce the burden of out-of-pocket expenses for health care
- Develop health safety nets for poor women and children
- Community-based interventions benefit from the required amount of monitoring and supervision
- Opportunity costs for poor to participate at activities related to community-based interventions for MNCH are covered
- Test innovative approaches in pilot districts (cash transfer, equity funds)

Strategy 1.3 Improve Health Information for better planning, monitoring and evaluation of maternal, neonatal and child health and related services**Expected Result 1.3.1**

Data collection from National Programmes and other projects is harmonized to achieve integrated MNCH data collection process

Activities

- Collect and review all existing data collection forms
- Develop integrated MNCH data collection form
- Ensure data collection for MNCH is linked to national health management information system (HMIS)
- Orientate health centre managers to new MNCH data collection process

Expected Result 1.3.2

Sentinel sites are established at health facilities in each province to collect MNCH outcome indicators

Activities

- Identify 2-3 health centres around which sentinel sites may be set up in each province
- Establish household survey techniques to be used at sentinel sites
- Train health workers from district and provincial level in survey techniques
- Establish data reporting methods
- Feedback data and arrange a review meeting at provincial level quarterly

Expected Result 1.3.3

Data collection and notification of births and deaths (maternal, perinatal, neonatal, and child) is strengthened and data used for program management

Activities

- Strengthen birth, death and **disability** registration
- Develop data collection forms or audit process for maternal, neonatal and child deaths at hospital level
- Introduce methods to review maternal mortality and obstetric complications at hospital level
- Review methods including verbal autopsy to review stillbirths, perinatal, neonatal and child deaths
- Identify and implement appropriate mechanisms to review maternal, neonatal and child mortality in the community
- Monthly hospital mortality meetings to review maternal, neonatal and child deaths with action outcomes

Expected Result 1.3.4

Regular monitoring of process indicators related to maternal, neonatal and child health, **including disability** and nutrition (EmONC, obstetric complications, institutional maternal and perinatal deaths, ENC, IMCI, institutional child mortality, nutrition indicators) is conducted

Activities

- Process indicators collected and reported quarterly
- Annual meeting to review process indicators

Strategic Objective 2: Strengthening efficiency and quality of health service provision

Strategy 2.1 Strengthen the delivery of MNCH services

Expected Result 2.1.1

Minimal requirements for the MNCH integrated package are implemented at all levels of health facilities

Activities

- Orientation of provincial/district facilitators
- **Orientate** all health care workers to national standards, protocols and guidelines for quality care of mothers, newborns and children, **including a disability component**
- Encourage regular supportive supervision by direct superior with immediate feedback at all levels of health facilities, including local registration and support to existing TBAs
- Encourage “on-the job” training and mentoring by direct superior at all levels of health facilities
- Health facilities schedule external supervisory visits at least on a quarterly basis - Provincial to District level, District to Health Centre level
- Health facilities schedule external supervisory visits at least on twice yearly basis - Central to Provincial level
- Introduction of accreditation of facilities which meet the minimum standards particularly for skilled care at birth and readiness for Emergency Obstetric and Newborn Care
- Disseminate the Mother and Child Handbook

Expected Result 2.1.2

A functional referral system is established at all levels of care for mothers, newborns and children

Activities

- Develop an effective communication system between health centres and district hospitals and district and provincial hospitals
- Ensure reliable financially viable transport arrangements are in place from each health facility
- Define referral criteria for maternal, neonatal and child health conditions
- Develop/revise form for referral of maternal, neonatal and child health conditions
- Ensure standard feedback mechanism from referral hospital to source of referral

Expected Result 2.1.3

Immunization services are mainstreamed in MNCH integrated package and their coverage increased

Activities

- Review district micro- plans on immunization including fixed site and outreach services
- Increase fixed site immunization where possible
- Expand the Hepatitis B birth dose
- Introduce new vaccines
- Immunization campaigns as needed
- Ensure additional components of the integrated MNCH package are provided when mothers and babies present for immunization
- Ensure all health workers at health facilities providing immunization are skilled in vaccination techniques, maintaining the cold chain and able to report/treat adverse events following immunization.
- Provide communication to mothers about benefits of immunization and other MNCH activities
- Strengthen the vaccine preventable disease surveillance system
- Develop health facility capacity to respond to adverse events, including anaphylaxis
- Monitor the provision and installation of refrigerators and other cold chain supplies and expansion of cold chain facilities to health centres
- Training of health workers on cold chain maintenance and effective vaccine management.

Expected Result 2.1.4

The organization of outreach activities from health centres and districts is improved to reach the most remote populations

Activities

- Develop protocols for outreach visits including a clear plan of villages to visit, staff to provide service, frequency of visits and service provided
- Ensure the implementation of an outreach service that supports of Reaching Every District (RED) strategy
- Develop criteria for monitoring and evaluation of outreach activities

Expected Result 2.1.5

Existing maternal, neonatal and child health activities are regularly reviewed and their organization is improved

Activities

- Introduce emergency obstetric and neonatal care into regular monitoring and supervision
- Ensure mothers remain in hospital for at least 24 hours after delivery for their safety and to optimize newborn survival
- Ensure facilities with deliveries have health workers skilled in neonatal resuscitation and SBA, or until sufficient SBAs have been trained have at least 1, ideally 2, staff fully trained on MNCH package
- Orient staff and create capacity for a routine postnatal visit for mother and newborn within 3-7 days after birth
- Conduct a collaborative IMCI review with all stakeholders, identify gaps in service delivery and disseminate lessons learned
- Ensure lessons learned are used to improve or incorporate IMCI into routine services at health centre level
- IMCI guidelines should be updated to include recommended technical updates including neonatal IMCI
- Introduce kangaroo mother care for low birth weight neonates

- Introduce and disseminate new growth charts
- Introduce referral system for early intervention when disability is detected

Expected Result 2.1.6

Referral care for mothers, neonates and children is improved

Activities

- Finalize plan for emergency triage assessment and treatment (ETAT) in Lao PDR
- Implement ETAT in all hospitals through cascade training, ensuring appropriate supplies and equipment and supervision
- Develop plan of for hospital assessments of mother, neonatal and child health services
- Conduct hospital assessments to define gaps in MNCH services
- Introduce hospital improvement process using quality improvement techniques based on hospital assessment findings
- Implement management of severe malnutrition in provincial and central hospitals

Expected Result 2.1.7

Wider method mix of FP services is available to respond to client needs

Activities

- Ensure female sterilization is available at central, provincial and District A hospitals and at District B hospitals by provincial teams
- Ensure IUD is available at all district hospitals and selected HC with high numbers of clients
- Ensure male sterilization is promoted at all hospitals (central, provincial and district)
- Selected FP interventions are delivered through supervised community health workers

Expected Result 2.1.8

Health facilities are progressively upgraded to provide the integrated package of MNCH services and EmONC according to national standards

Activities

- Conduct mapping of available services and requirements (infrastructure, staff, etc) to implement the MNCH package, including services for disabled children
- Develop plan for upgrading health facilities
- Develop criteria to certify improvement according to standards
- Develop accreditation system

Expected Result 2.1.9

Standards for an adequate building with functional amenities of all health facilities are established and baby, child, mother and youth friendly services are provided by all health facilities

Activities

- Develop standards for structure of health facilities including disability accessibility
- Ensure health facilities are built to standards with functional amenities (toilet, washing area), including disability accessibility
- Ensure there is a budget available for necessary repairs and repairs are completed in a timely fashion
- Ensure availability of area for sleeping and cooking in hospitals for mothers and children
- Baby friendly hospital initiative is revitalized
- Ensure privacy in the provision of MNCH services at all levels
- Ensure informed consensus for MNCH interventions

Strategy 2.2: Develop sufficient and skilled Health Workforce for the provision of the MNCH integrated package

Details for implementation of the HR Plan for Skilled Birth Attendance will be found in the SBA Development Plan, MOH 2008. Additional component will need to be added to this, to cover child health and training of managers and supervisors for integrated service delivery.

Expected Result 2.2.1

Human resources needs for reaching universal coverage of the MNCH package are mapped (skilled birth attendants and additional staff for pediatric services)

Activities

- Disseminate and implement the SBA plan
- Estimate number of SBA needed for different levels of coverage
- Map additional staff needs for different levels of coverage at different levels of the health system
- Develop HRH plan for MNCH package as part of the national HRH plan

Expected Result 2.2.2

Training of human resources for implementation of the integrated MNCH package conducted

Activities

- Strengthen training institutions (Nursing School, Medical School) to support the formal training on MNCH
- Revise the curriculum of health care providers to ensure the inclusion of the interventions of the integrated package and BEmONC in the formal training of nurses and CEmONC in the training of medical doctors and technicians of surgery
- Provide in-service training of nurses in the integrated package components to improve antenatal, delivery, post-natal care and family planning
- Provide in-service training for district and dispensary staff on MNCH management
- Provide in-service training on IMCI for health staff working in service delivery
- Include IMCI technical updates in the formal training of MCH nurses, and other medical staff
- **Introduce a disability component in the curriculum on prevention, detection and early intervention**
- Introduce competency based training of health workers in contraceptive counselling for couples, women and men
- Introduce performance based incentives to improve services for maternal, neonatal, and child health
- Ensure follow-up after training for health workers at place of work 4-6 weeks after training course completed
- Re-orient the role of the traditional birth attendant to provide linkages between the community and the health facility and to promote facility births and early referral for danger signs

Expected Result 2.2.3

Deployment of sufficient and skilled staff for the provision of MNCH services is ensured

Activities

- Develop deployment plan of staff required for MNCH services, according to national standards, needs and available resources, as part of the national HRH plan

Expected Result 2.2.4

Supportive supervision and career development

Activities

- Develop clear pathways within Human Resources for Health policy and strategic plan
- Provide training in supportive supervision
- Conduct regular supervision of health staff

Expected Result 2.2.5

Linkages between health facilities and communities are facilitated by MNCH staff

Activities

- Regular meetings are held between health facility representatives and community representatives concerning the functioning of the health facility, timing of outreach MNCH activities and their content, as well as consideration of community concerns and desires
- During outreach services an open dialogue between health service providers and users is facilitated

Strategy 3: Improve the management of Medical Products and Technology for MNCH services

Expected Result 2.3.1

Regular supply of an essential package of drugs and other health commodities for implementation of the integrated MNCH package is ensured

Activities

- Develop standard checklist and system for regular supply of medicines and commodities for family planning and maternal services (family planning kit, delivery kit, Emergency Obstetric Surgery kit, health promotion materials, **basic rehabilitation equipment**)
- Develop standard checklist and system for regular supply of medicines and commodities for neonatal care, IMCI and Paediatric hospital care services (including IMCI recording forms, health promotion and **disability awareness** materials)
- Develop standard checklist for medicines and commodities for outreach visits
- Ensure standard set of maternal, neonatal and child health education and promotion materials are available at all levels of facilities
- Develop, print and distribute standard operating procedure posters on vaccine management and cold chain maintenance
- Support to the provision of annual needs of routine vaccines and EPI supplies
- Expand the contraceptive LMIS and include data on supply and dispensing of all centrally procured MNCH commodities
- Develop standard monthly report for MNCH commodities
- Develop joint plan for MCH/FDD and definition of respective roles and responsibilities to ensure improved integration at different levels (central, provincial, district)
- Progressively move from different systems to one logistics and management system
- Include contraceptives in drug revolving fund list
- Training of Provincial and Health staff in logistics

Strategic Objective 3: Mobilising individuals, families and communities for MNCH

Strategy 1: Create a supportive environment for the involvement of individuals, families and communities in MNCH

Expected Result 3.1.1

Through sensitization and advocacy, a supportive environment is fostered, at all levels and in all sectors of government, towards the participation of individuals, families and communities (IFC) in improving MNCH

Activities

- Hold National Orientation on Working with IFC to improve MNCH, with participation from provincial and district levels

- Create a multi-sectoral committee to promote collaboration on, and mobilize resources for, community-based initiatives for MNCH; committee to meet at least quarterly
- Adopt a National Policy on Community Participation for Health
- Develop a plan for community participation in each district
- Develop a behavioural change communication strategy including hygiene, infant and young child feeding, danger signs for pregnant women, neonates and children and when to seek care and implementation of birth preparedness and emergency plan and transport in case of emergency
- Review existing IEC materials on maternal, child health and nutrition and based on successes develop and replicate set of materials for community program
- Develop training plan for LWU, CHWs and TBAs and other community based individuals and groups in each district

Expected Result 3.1.2

Through sensitization and capacity building, provincial and district level health workers will be enabled to work effectively with IFCs in improving MNCH

Activities

- Provide training in effective counselling for MNCH to provincial, district and HC health workers (these materials to be adapted for local context from WHO Toolkit)
- Develop and conduct a provincial/district training on "Promotion by Health workers of Key Family Practices for IMCI, and Community-level Integrated Case Management of Childhood Illness" and maternal health promotion including recognition of danger signs, birth and emergency preparedness plan, and transport in case of emergency and post-natal care
- Develop and conduct a provincial/district level Training of Trainers on "Facilitation in Working with IFCs to improve MNCH"
- **Develop and conduct training at provincial, district and health centre levels on prevention, detection and early intervention on disability**
- Conduct Cascade Training for HC health workers
- Support quarterly meetings of all HC facilitators/trainers with district master trainers
- Support Health Promotion activities conducted by district and HC health workers at health facilities and during outreach
- Establish liaison persons between community and health workers

Strategy 2: Develop Community Participation mechanisms for better MNCH

Expected Result 3.2.1

Through sensitization, capacity building and greater integration into existing health promotion efforts, IFCs will be enabled to participate effectively in improving MNCH

Activities

- Meet with village leaders, members of Village Health Committee (VHC) and Lao Women's Union (LWU) and other existing community individuals and groups to orient them on the MNCH package and plan for Community Participatory Assessments (CPAs)
- Conduct CPAs at the village level to determine local priorities in MNCH and to choose village representatives to become facilitators/motivators
- Support necessary training for VHCs to address priorities as identified through CPA process
- Where identified by CPA as priority, provide training in facilitation to village representatives
- Support quarterly meetings of all community facilitators with district master trainers (pilot: 8 meetings annually)
- Support 6-monthly public forums/visits to HCs to improve communication and collaboration between community members and health workers (40 meetings annually for pilot)
- Develop mechanisms for IFC participation in data collection for monitoring and evaluation
- Develop and promote household birth and growth registration cards

- Implement mechanism for Village Health Committee participation in investigation of maternal and infant deaths, including child with disability deaths

Expected Result 3.2.2

Provision of interventions and medications for mothers and children in hard to reach areas

Activities

- Define which areas and villages should have medication provided by community based individuals
- Define limited number of medications to be provided and criteria for administration
- Orientate community based individuals and groups to provide a limited number of medications to mothers and children in hard to reach areas
- Ensure that VHWs promote use of ORS for diarrhoea in hard to reach areas
- Community based individuals and groups to provide iron tablets for pregnant women
- Promote community management of pneumonia
- Expansion of FP provision by CBDs to northern and central provinces
- Village revolving drug funds are regularly supervised and monitored, its operators timely refreshed and stocks replenished when required
- Support CM private practice

Expected Result 3.2.3

IFC participation in the creation of IEC materials will be expanded

Activities

- Coordinate multi-sectoral database to establish extent of existing IEC materials
- With community input, develop and introduce clear postings of MNCH service costs and availability at provincial/district/HC facilities
- Where identified through VHCs or other community mechanisms, provide support for the production of locally tailored IEC materials

Expected Result 3.2.4

IFC participation will be expanded in developing referral services, including finding solutions to transportation barriers that impact MNCH

Activities

- Incorporate emergency and normal transport issues in the Community Participatory Assessments (CPAs)
- Ensure integrated package of care during the outreach services that have been planned in consultation with the target communities and are executed in a timely manner
- Promote communal micro-saving initiatives to ensure availability of sufficient cash at grassroots level for paying (emergency) transport

Expected Result 3.2.5

Multi-sectoral IFC approaches to improving nutrition will be developed

Activities

- Provide peer support to pregnant and lactating women to encourage provision of colostrum, immediate and exclusive breastfeeding and complementary feeding
- Provide appropriate care for child diseases such as pneumonia and diarrhoea
- Ensure sufficient stock of micronutrients, de-worming drugs and nutrition supplies at village level
- Include hand washing with soap in the educational package
- Introduce community management of acute severe malnutrition

Expected Result 3.2.6

Multi-sectoral approaches to promoting IFC participation for MNCH through the education system will be developed

Activities

- Promote MNCH as a broader issue than access to health care alone
- Establish peer support for healthy MNCH practices
- Develop communal activities for a healthy environment
- Introduce a standardised though locally adaptable curriculum for health education at school, including disability component

Expected Result 3.2.7

Multi-sectoral approaches to promoting gender equity using IFC-level initiatives will co-ordinate to improve MNCH

Activities

- Orient and train MNCH managers and health staff in gender equality and use of gender analysis in planning and programme management
- Introduce collection of gender disaggregated data
- Introduce gender based data analysis in planning, M/E processes for MNCH
- Develop activities to promote gender equality at health facility and community level to increase appropriate response to MNCH needs and use of MNCH services

Expected Result 3.2.8

Medical practices will be reviewed to accommodate women concerns and traditions (companion in childbirth, free position at delivery, fire bed, etc.)

Activities

- Conduct ethnographic studies amongst ethnic groups to determine culturally appropriate but medically harmless practices surrounding pregnancy, delivery, (breast)feeding and maternal and child health practices
- Train health care practitioners in employing such practices and using culturally and locally appropriate language according to ethnicity of the women and children
- Equip health facilities to enable locally preferred practices surrounding MNCH

7. Monitoring and Evaluation

7.1. Indicators for Monitoring the Integrated MNCH Package

A common set of indicators should be used for monitoring and evaluation of maternal, neonatal and child health activities by all stakeholders. An indicator is a measurement that is repeated over time to track progress towards achieving goals and objectives. In monitoring the Integrated MNCH package different types of indicators will be used.

Table 4. Indicators

Indicator	Definition
Input	Measures resources needed to conduct programme activities, includes financial, human and material resources
Output (Process)	Measures whether the supports needed to deliver interventions or improve population coverage with interventions are in place, includes proportion of planned training courses completed or supervisory visits conducted or proportion of facilities with essential drugs or vaccines available, facility based measures of quality of care
Outcome	Measures whether mothers or children have received interventions, includes population based intervention coverage
Impact	Measures whether health of women and children has changed includes measures of mortality, morbidity or nutritional status

Impact and outcome indicators are currently collected every 3-5 years through the Lao National Population and Housing Census, Laos PDR Multiple Indicator Cluster Survey and the Reproductive Health Survey conducted by the National Statistical Centre of the Ministry of Planning and Investment and the Ministry of Health. On a yearly basis, between the large-scale nationally representative surveys, small-scale representative surveys of MNCH interventions should be conducted at sentinel sites to collect outcome indicators. All health measurements should report data for children under five separately, preferably disaggregated for age (neonatal, post-neonatal and child) and gender.

Process indicators are currently collected through responsible programmes and reported from health facility to district, provincial and collated at central level. Each programme has its own reporting mechanism and there is no uniform data collection form for MNCH activities. The quality of the data collected should be strengthened and data collection processes at health facility and district level should be harmonized as much as possible. A HMIS is under development.

7.2. MNCH Scorecard for Monitoring

A scorecard approach to monitoring MNCH intervention delivery is suggested for national, provincial and district levels to provide a clear visual display of progress in achieving targets in outcomes for maternal, neonatal and child health. If progress is good this is encouraging and if poor this may assist as a reminder of the need for accelerating activity.

Table 5. Scorecard on MNCH Progress – National Level Framework

	Baseline		Current level	Target	
	2000	2005		2010	2015
Impact Indicators					
Maternal mortality	530	405	NA	330	260
Under five mortality (per thousand)	106	98	NA	75	55
Infant mortality (per thousand)	82	70	NA	55	45
Prevalence of malnourished under-five children (%)	40	37.9	37.1	32	25
Outcome Indicators (%)					
Family Planning					
Contraceptive Prevalence Rate		38	40	45	55
Number of users by method at fixed sites and at outreach		NA	NA		
Pregnancy, Delivery and Postnatal period for Mother					
Proportion of antenatal care (1 visit)	NA	28.5	NA	45	60
Proportion of antenatal care (4 visits)	NA	NA	NA	20	40
Caesarean section rate by province	NA	NA	NA		
Proportion of birth in facilities	NA	12.8	NA	20	30
Proportion of births attended by skilled birth attendants (%)	19.4*	21.1*	NA	35	50
Proportion of mothers received full course of neonatal tetanus immunization (Protection at birth)	58	50	47	80	80
Proportion of iron supplementation in pregnancy	NA	23	NA	50	75
Proportion of postnatal care (at least 1 visit within 7 days)	NA	NA	NA	35	50
Proportion of postnatal care (at least 1 visit within 6 weeks)	27	NA	NA	35	60
Proportion of iron supplementation to postpartum women	NA	NA	NA	30	60
Proportion of Vitamin A supplementation to postpartum women	NA	NA	6	30	60
# of pregnant mothers receiving VCCT and know their HIV status					
Child Health Care					
Proportion of infants with breastfeeding initiated within one hour of birth	NA	NA	29.8	50	80
Proportion of infant within 6 months exclusive breastfed	23	NA	26.4	50	80
Proportion of infant of 6-9 months receiving breast-milk and complementary food	NA	NA	70.5	80	90
Proportion of 1 year-old children immunized against measles (%)	41.8	40.4	40	80	90
Proportion of 1 year-old children immunized against DPT-HepB3 (%)					
Proportion of Vitamin A supplementary to children aged 6-59 months	NA	33	92	90	90
Proportion of children with diarrhea treated with ORT	NA	NA	50.5	60	80
Proportion of children with suspected pneumonia treated with antibiotics	NA	NA	41.1	60	80
Proportion of children slept under insecticide treated bed-nets	NA	NA	40.5	60	80

* Proportion of births attended by health workers, non necessarily SBA (doctors, midwives, nurses, medical assistants)

7.3. Monitoring and Evaluation Coordination and Reporting

Monitoring: All stakeholders working on maternal, neonatal and child health activities should conduct joint activities to monitor progress using the standardized scorecard monitoring framework. The information should be used to inform the annual planning.

- Joint annual or biennial progress assessments with participation of related international organizations.
- Annual or biennial national MNCH review workshop with participation of provincial government officials. The meeting should present the progress made by provinces, share experiences, identify problem and propose solutions.

Evaluation: Evaluation of progress in reducing maternal, neonatal and child mortality will be conducted every five years in Lao PDR through the Multiple Indicator Cluster Surveys (MICS), Lao National Population and Housing Census and the Lao Reproductive Health Survey. These surveys were last conducted in 2005 and will be repeated in 2010 then 2015.

Data on intervention coverage should be collated by the MNCH team at district level and reported to provincial then central level. The MCH/EPI technical working group should be responsible for reporting coverage of key intervention delivery to determine progress. This information should be communicated to all stakeholders involved in MNCH activities and also to the community. The MCH/EPI TWG should ensure that the highest level of government, the Health Sector Working Group and the National Commission for Mother and Child have MNCH intervention coverage information so that appropriate action can be taken if progress is poor.

8. Roles and responsibilities

8.1 Multi-sectoral level

- The Laos National Committee for Mother and Children are responsible for maternal, neonatal and child health coordination across sectors
- The Government of Lao PDR and maternal, neonatal and child health partners in Laos will work with all levels of Government, local and international NGOs, and civil society to achieve universal coverage for the core set of MNCH interventions
- The Government of Lao PDR and partners commit to review regularly progress with increasing resources for and coverage of the core set of interventions
- Inter-ministerial links between MOH and Ministry of Planning and Investment, Ministry of Finance, Ministry of Education, Ministry of Agriculture and other ministries responsible for water and sanitation will be ensured
- The Global Partnership for Maternal, Newborn and Child Health and other global initiative assure sustained support to Lao PDR in its effort to reduce maternal, neonatal and child mortality

8.2. Central level MOH

- Hosting the MCH/EPI technical working group
- Hosting the Sector Working Group operational level and policy level to coordinate planning and implementation of the Integrated MNCH Package
- Ensuring that all programmes that manage MNCH interventions implement tasks in a coordinated manner to achieve integration as much as possible

- Communication with: sub-national level including provincial and district health offices, Technical agencies (WHO, UNICEF, UNFPA), National hospitals, Academic institutions: Universities, Medical and Nursing Schools, Multilateral and bilateral agencies and NGOs, Private sector, Medical, Nursing and Pharmacy associations, National Commission on Mother and Children
- Policy formulation: national standards setting, regulatory mechanisms for service providers, human resources and health financing
- Ensuring legal procedures: enforcement of the regulation on the marketing of products for IYCF, regulation of health care providers

8.3. National Programmes and Projects (IMCI, Immunization, Safe Motherhood)

- Implement components of the MNCH Package in an integrated manner at community level, through outreach services, first and referral level facilities, and national hospitals
- Provide training and supervision role in implementing interventions
- Conduct surveillance, monitoring and evaluation of interventions
- Coordinate with other programmes to combine interventions

8.4. National and Teaching Hospitals

- Main referral centres for specialised care of pregnant women and sick children in the country
- Pre-service and in-service training
- Standard setting for obstetric and paediatric care
- Pool of technical experts (Obstetricians and paediatricians) as trainers in national training programmes, adaptation of guidelines
- Supervisory role for provincial hospitals
- Collection of national hospital statistics

8.5. Provincial Health Departments

- Supervision and management of districts
- Assist districts in planning and resource allocation for planning process
- Liaison with central level and national programmes
- Management and administrative function for provincial referral hospitals

8.5.1. District Health Departments

- Supervision, management and administrative function for district referral hospitals and health centres
- Assist health centres in planning and resource allocation for planning process
- Liaison with provincial health departments and national programmes

8.5.2. Referral hospitals

- Give priority attention to wards for mothers, babies and children
- Provide emergency obstetric and newborn care (basic or comprehensive)
- Provide emergency, triage assessment and treatment of children
- Manage sick children using standard treatment guidelines
- Ensure adequate hospital policies, material resources, drugs and commodities for care of mothers and children
- Give priority to staff training for care of mothers and children
- Supervision
- Monitoring and evaluation
- Community liaison

8.5.3. Health centre level

- Implement all MNCH interventions at health centre
- Provide outreach and referral
- Community liaison

8.6. Academic institutions

- Provision of pre-service and in-service maternal and child health education
- Technical expertise and expert opinions on new programmes, projects and standards setting

8.7. Private sector

8.7.1. Trained private practitioners

- Manage pregnant women, neonates and sick children using Laos standard treatment guidelines
- Provision of health promotion and preventive interventions to the community
- Refer pregnant women and children with danger signs to appropriate referral level facility

8.7.2. Drug outlets

- Pharmacies dispense non-prescription and prescription registered drugs and provide educational materials and basic counselling on MNCH interventions
- Pharmacy depots dispense non-prescription and a restricted list of prescription registered drugs and provide educational materials and basic counselling on MNCH interventions
- Informal drug sellers and general commodity shops dispense non-prescription (over the counter) registered drugs for self-medication and provide educational materials and basic counselling on MNCH interventions
- Refer pregnant women and children with danger signs to public health facility

8.7.3. Traditional birth attendants and Community Health Workers

- Advise pregnant women to seek skilled birth attendance
- Refer infants, children and mothers with danger signs to public health facility
- Give advice on keeping the baby warm, skin-to-skin contact and early initiation of breastfeeding
- Dispense non-prescription commodities, e.g. soap, ORS, ITN
- In remote communities with no access to formal health care services, Community Health workers (CHW) provide selected MNCH interventions under close supervision

8.8. UN agencies, Bilateral agencies and NGOs programmes

- Technical and funding support to maternal, neonatal and child health activities
- Coordination to deliver and promote MNCH interventions by strengthening primary health care based health system
- Ensure that maternal, neonatal and child health interventions are implemented and monitored using the accepted framework
- Refer pregnant women and children with danger signs to appropriate referral level facility
- Liaison with MOH at all levels

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Annex 1. MNCH Package Implementation Plan

Strategic Objective 1: Improving leadership, governance and management capacity for programme implementation

Expected Result	Activities	Responsibilities	Product	Means of Verification	Support Partners	Timeframe 2009-2015						
						9	10	11	12	13	14	15
Strategy 1.1 Strengthen leadership and governance for MNCH												
1.1.1 One coordination mechanism, one national plan and one monitoring and evaluation process is established for all stakeholders working on maternal, neonatal and child health activities in Lao PDR and coordination is strengthened at all levels of the health system	1.1.1.1 A national mechanism established to coordinate ongoing planning for implementation of the Integrated Package of Maternal, Neonatal and Child Health Services based on the strategy document	DHP DOP MNCH TWG SWC	National MNCH Coordinating Body with TOR (Jul 09)	TOR	WHO JICA UNFPA UNICEF	X						
	1.1.1.2 The strategy is accepted by all stakeholders as the definitive budgeted plan for maternal, neonatal and child health in Lao PDR	DHP DPF	Ministerial Decree (Dec 09)	Decree	ALL	X						
	1.1.1.3 The monitoring and evaluation framework is accepted and adhered to by all stakeholders	DHP DOS	Ministerial Decree (Dec 09)	Decree	ALL	X						
	1.1.1.4 MNCH Technical working group review progress quarterly and reports to Health Sector Working Group and National Commission of Mother and Child	MNCH TWG	Quarterly reports	Reports		X	X	X	X	X	X	X
	1.1.1.5 Regular meetings are held with TWGs on planning and financing, human resources for health and nutrition	MNCH TWG	Minutes of meetings		ALL	X	X	X	X	X	X	X
1.1.2. Policies are developed and national standards, protocols and guidelines for MNCH integrated package are defined and disseminated	1.1.2.1 Develop and approve a policy and guidelines of supervision of health workers at all health facilities and for outreach and community midwives in private practice in the community	SWC			WHO UNICEF	X						
	1.1.2.2 Develop and approve a policy and guidelines on performance incentives for fixed site intervention delivery	DPF DOP DHP			WHO UNICEF WB	X						
	1.1.2.3 Develop and approve a policy and guidelines for outreach including per diem and incentives for out-of – facility births by SBA	DHP DOP DPF				X						
	1.1.2.4 Develop and approve a policy and guidelines for weekly iron and	DHP DFD			WHO UNICEF	X						

	folate supplementation in WRA											
	1.1.2.5 Develop and approve a national strategy and plan on Maternity Waiting Homes	DHP			WHO	X						
	1.1.2.6 Develop national strategy for deployment of maternal, neonatal and child health workforce in districts according to need	DHP DPF DHP			WHO UNFPA UNICEF	X						
	1.1.2.7 Finalize Manual of Operation Procedures for MNCH services	DHP DOC DOP FDD MNCH TWG	Manual of Operation Procedures finalized and launched	Manual of Operation Procedures	WHO	X						
	1.1.2.8 Disseminate the Manual of Operation Procedures	DHP MCH Centre	Manual of Operation Procedures finalized and launched	Manual of Operation Procedures	WHO	X	X					
	1.1.2.9 Update clinical protocols and guidelines for integrated MNCH services as needed	DHP DOC MNCH TWG		Updated protocols and guidelines for integrated MNCH services	WHO UNFPA UNICEF	X						
	1.1.2.10 Disseminate clinical protocols and guidelines for integrated MNCH services	DOC DHP			WHO UNFPA UNICEF	X	X					
	1.1.2.11 Develop policy regulation on SBA practice to include scope of midwifery practice, and licensing and re-licensing of SBA											
	1.1.2.12 Develop policy for accreditation of health facilities which meet the minimum standards	DHP										
	1.1.2.13 Update Mother and Child Handbook	DHP			UNICEF							
	1.1.2.14 Develop a policy and guidelines on prevention, detection and early intervention for disabilities	DOC			Handicap International							
1.1.3. MNCH staff capacity on management and supervision of health MNCH services is strengthened at central, provincial and district level	1.1.3.1 Orient staff on the MNCH package, requirements, roles and responsibilities	DHP DOC			WHO UNFPA UNICEF	X	X	X	X	X	X	X
	1.1.3.2 Train key central, provincial and district level health personnel in a package of: methods of management and supervision, utilization of national standards, protocols and guidelines, situation analysis (including data analysis and dissemination), definition of priority interventions, monitoring, evaluation	DHP DOC DOP DPF DOS	Develop training package (May 09) Training in 6 provinces/10 districts (Jun 09)	Training materials Training reports	WHO UNICEF	X	X	X	X	X	X	X

	methods, report writing and basic computer software package (Excel and Word)											
	1.1.3.3 Develop standard monitoring and supervision tools including administrative and technical components for maternal, neonatal and child health	MNCH TWG DHP	Review existing materials Develop monitoring and supervision tools (Jun 09)	Report Tools	WHO	X						
	1.1.3.4 Undertake 4 integrated monitoring and supervision visits to each level of health facility per year	MCH Centre MNCH P team MNCH D team	Monitoring reports including feedback quarterly	Reports		X	X	X	X	X	X	X

	1.1.3.5 Ensure supervision visits to each level of health facility by specific program (immunization, safe motherhood, IMCI, nutrition) once per year	MCH Centre MCH Hospital MNCH P team MNCH D team	Supervision reports yearly	Reports		X	X	X	X	X	X	X
	1.1.3.6 Ensure feedback from each monitoring visit	MCH Centre MCH Hospital MNCH P team MNCH D team	Monitoring reports including feedback quarterly	Reports		X	X	X	X	X	X	X
1.1.4. A well defined team for the implementation of the integrated MNCH package is established at provincial and district level	1.1.4.1 Develop Terms of Reference for teams and appoint members	DOC DHP	MNCH team TOR (Mar 09) MNCH team appointed (Jun 09)	TOR List of members		X						
	1.1.4.2 Provincial Health Department to convene annual meeting with all districts to ensure integrated MNCH package is incorporated in budgeted annual operational plans for districts	DHP DPF	First provincial health department meeting with each district (Jul 09) District annual operational plans including MNCH (Jul 09)	Meeting minutes		X	X	X	X	X	X	X
	1.1.4.3 Ensure annual operational plans include budget for monitoring and supervision	DPF DHP	District annual operational plans including MNCH (Jul 09)	District plans	UNICEF	X	X	X	X	X	X	X
	1.1.4.4 Ensure provincial health department harmonises all district plans to reflect integrated MNCH package	PHD MNCH P team	District plans for MNCH incorporated to provincial plan (Aug 09)	Provincial plans	WHO UNICEF	X	X	X	X	X	X	X
	1.1.4.5 Conduct quarterly meetings at all levels to review service provision and findings of monitoring and supervision using quality improvement methodology	DOS DHP MNCH P team MNCH D team	Quarterly meeting reports	Reports		X	X	X	X	X	X	X
1.1.5. A national committee on maternal neonatal and child deaths is created and functions	1.1.5.1 Develop Terms of Reference for national committee on maternal neonatal and child deaths, including	NIPH MCH Hospital MNCH TWG	TOR for national committee on maternal neonatal	TOR	WHO UNFPA UNICEF	X						

regularly	child with disability deaths		and child deaths (Dec 09)									
	1.1.5.2 Appoint committee members and convene first meeting	NIPH MCH Hospital	Committee members appointed and first meeting convened (Dec 09)	Minutes of meeting		X						
	1.1.5.3 Develop support structure for provincial and district committees	NIPH MCH Hospital MNCH TWG	Support structure for provincial and district committees developed (Dec 09)	Organogram			X					

	1.1.5.4 Work with central hospitals and statistics department of MOH to develop methods of reviewing maternal, neonatal and child deaths, including child with disability deaths	NIPH DOS MCH Hospital MNCH TWG	MOU between national committee and central hospitals and statistics department of MOH signed (Dec 09)	MOU		X	X					
1.1.6. Provincial and district committees on maternal neonatal and child deaths are established and supported	1.1.6.1 Develop Terms of Reference for provincial and district committee on maternal neonatal and child deaths, including child with disability deaths	NIPH MCH Hospital MNCH TWG	TOR for provincial and district committees on maternal neonatal and child deaths (2010)	TOR		X						
	1.1.6.2 Orientate and create capacity at provincial and district levels to report and investigate maternal, neonatal and child deaths and to use data for improving MNCH service provision	NIPH DOS MCH Hospital MCH Centre					X					
	1.1.6.3 Conduct biannual meetings at provincial level to discuss district, health facility and community data	NIPH MCH Hospital MCH Centre					X	X	X	X	X	X

Strategy 1.2: Develop financing mechanisms for increasing access to MNCH services

1.2.1 The forthcoming Health Financing Strategy includes financing modalities to increase the provision of MNCH services	1.2.1.1 Develop a uniform per diem and incentive system for public health staff members for effective MNCH service delivery with staff remuneration linked to performance	DPF MNCH TWG			WHO WB UNICEF	X						
	1.2.1.2 Develop mechanisms to reduce inefficiencies in management of the health services in general	DPF MNCH TWG			WHO WB UNICEF	X						
	1.2.1.3 Develop alternative finance	DPF			WHO	X						

	mechanisms to the revolving drug funds at secondary and tertiary level that reduce use and prescription of unnecessary tests and drugs and promote delivery of essential MNCH services	MNCH TWG										
1.2.2 The forthcoming Health Financing Strategy includes financing mechanisms to increase utilization of MNCH services	1.2.2.1 Develop mechanisms to reduce the burden of out-of-pocket expenses for health care	DPF			WHO WB LuxDev	X						
	1.2.2.2 Develop health safety nets for poor women and children	DPF DHP			WHO WB LuxDev	X						

	1.2.2.3 Community-based interventions benefit from the required amount of monitoring and supervision	DHP				X	X	X	X	X	X	X
	1.1.2.4 Opportunity costs for poor to participate at activities related to community-based interventions for MNCH are covered	DPF			WHO WB LuxDev	X	X	X	X	X	X	X
	1.1.2.5 Test innovative approaches in pilot districts (cash transfer, equity funds)	DHP DPF			WHO WB LuxDev	X	X	X	X			
Strategy 1.3: Improve Health Information for better planning, monitoring and evaluation of maternal, neonatal and child health and related services												
1.3.1. Data collection from National Programmes and other projects is harmonized to achieve integrated MNCH data collection process	1.3.1.1 Collect and review all existing data collection forms	DOS MNCH TWG	Data collection forms reviewed	Report	WHO	X						
	1.3.1.2 Develop integrated MNCH data collection form	DOS MNCH TWG	Integrated MNCH data collection form (Jun 09)	Form	WHO UNICEF	X						
	1.3.1.3 Ensure data collection for MNCH is linked to national health management information system (HMIS)	MNCH TWG			WHO EU	X						
	1.3.1.4 Orientate health centre managers to new MNCH data collection process	DOS DHP	Health centre manager orientation to data collection process in 6 provinces/6 districts (Aug 09)	Report of orientation	WHO	X	X					
1.3.2 Sentinel sites are established at health facilities in each province to collect MNCH outcome indicators	1.3.2.1 Identify 2-3 health centres around which sentinel sites may be set up in each province	MCH Centre	Sites identified in 6 provinces/6 districts (July 09)	Site names	WHO	X						

	1.3.2.2 Establish household survey techniques to be used at sentinel sites	DOS	Survey techniques identified and training course developed 9 (Oct 09)	Training course		X						
	1.3.2.3 Train health workers from district and provincial level in survey techniques	DOS	Training in sentinel sites in 6 provinces/10 districts (Dec 09)	Report of training			X	X				
	1.3.2.4 Establish data reporting methods	DOS	Established in 6 provinces/10 districts (Dec 09)	Reporting methods		X						
	1.3.2.5 Feedback data and arrange a review meeting at provincial level quarterly	DOS DHP	Quarterly meeting reports				X	X	X	X	X	X

1.3.3. Data collection and notification of births and deaths (maternal, perinatal, neonatal, and child) is strengthened and data used for program management	1.3.3.1 Strengthen birth, death and disability registration	DOS	Birth and death registration processes in 6 provinces/10 districts reviewed (Aug 09)	Report		X	X					
	1.3.3.2 Develop data collection forms or audit process for maternal, neonatal and child deaths at hospital level	MCH Hospital MCH Centre NIPH DOS	Mortality data collection process/form developed for 6 provinces/6 districts (Oct 09)	Form	WHO	X						
	1.3.3.3 Introduce methods to review maternal mortality and obstetric complications at hospital level	MCH Hospital MCH Centre	Plan developed for 6 provinces/6 districts (Dec 09) Introduced 2010	Plan	WHO	X	X					
	1.3.3.4 Review methods including verbal autopsy to review stillbirths, perinatal, neonatal and child deaths	MCH Hospital MCH Centre NIPH DOS	Methods reviewed 2010	Report	WHO	X						
	1.3.3.5 Identify and implement appropriate mechanisms to review maternal, neonatal and child mortality in the community	MCH Centre NIPH DOS	2009		WHO	X	X					
	1.3.3.6 Monthly hospital mortality meetings to review maternal, neonatal and child deaths with action outcomes	MCH Hospital MCH Centre NIPH DOS	Monthly meeting commenced in 6 provinces/6 districts (2010)	Meeting minutes		X	X	X	X	X	X	X
1.3.4. Regular monitoring of process indicators related to maternal, neonatal and child health including disability and nutrition (EmONC, obstetric complications, institutional	1.3.4.1 Process indicators collected and reported quarterly	DOS MCH Hospital MCH Centre NIPH	Annual report in 6 provinces/6 districts (Dec 09)	Annual report	WHO	X	X	X	X	X	X	X

maternal and perinatal deaths, ENC, IMCI, institutional child mortality) is conducted												
	1.3.4.2 Annual meeting to review process indicators	DOS MCH Hospital MCH Centre NIPH	Annual meeting in 6 provinces/6 districts (Dec 09)	Meeting minutes		X	X	X	X	X	X	X

Strategic Objective 2: Strengthening efficiency and quality of health service provision

Expected Result	Activities	Responsibilities	Product	Means of verification	Support Partners	Timeframe 2009-2015						
						9	10	11	12	13	14	15
Strategy 2.1: Strengthen the delivery of MNCH services												
2.1.1 Minimal requirements for the integrated MNCH package are implemented at all levels of health facilities	2.1.1.1.Orientation of provincial/district facilitators	MOH, Hygiene Prevention Department MCH centre	Trained 10 facilitators in each province	Training report & observation	All partners	X	X					
	2.1.1.2 Orientate all health care workers to national standards, protocols and guidelines for quality care of mothers, newborns and children including a disability component	MOH, Hygiene Prevention Department MCH centre	All health workers orientated	Report	All partners	X	X	X	X			
	2.1.1.3. Encourage regular supportive supervision by direct superior with immediate feedback at all levels of health facilities including local registration and support to existing TBAs	MOH, Hygiene Prevention Department MCH centre	Supervision & training reports quarterly	Reports		X	X	X	X	X	X	X
	2.1.1.4. Encourage “on-the job” training and mentoring by direct superior at all levels of health facilities	MOH, Hygiene Prevention Department MCH centre	Supervision & training reports quarterly	Reports		X	X	X	X	X	X	X
	2.1.1.5.Health facilities schedule external supervisory visits at least on a quarterly basis ➤ Provincial to district level ➤ District to health centre level	MOH Mother & Child Commission	Quarterly visit reports	Reports		X	X	X	X	X	X	X
	2.1.1.6 Health facilities schedule external supervisory visits at least on twice yearly basis ➤ Central to provincial level	MOH Mother & Child Commission	Quarterly visit reports	Reports		X	X	X	X	X	X	X
	2.1.1.7 Introduction of standards and accreditation of facilities which meet the minimum standards particularly for readiness for Emergency Obstetric and Newborn Care	DOC MCH Centre	Standard developed Facilities accredited	Standards introduced Accreditation certificate		X	X	X	X	X	X	X
	2.1.1.8 Disseminate the Mother and Child Handbook	MOH			UNICEF							
2.1.2. A functional referral system is established at all levels of care for mothers, newborns and children	2.1.2.1 Develop an effective communication system between health centres and district hospitals and district and provincial hospitals	MOH	System developed and implemented	Document		X	X	X	X	X	X	X
	2.1.2.2 Ensure reliable financially viable transport arrangements are in	MOH Local government	Arrangements developed	Document		X	X	X	X	X	X	X

	place from each health facility												
	2.1.2.3 Define referral criteria for maternal, neonatal and child health conditions	DHP, DOC MCHC	Endorsed document for referral and feedback criteria	Document		X							
	2.1.2.4. Develop/revise form for referral of maternal, neonatal and child health conditions	DHP, DOC MCHC	Endorsed document for referral and feedback criteria	Document		X							
	2.1.2.5 Ensure standard feedback mechanism from referral hospital to source of referral	DHP, DOC MCHC	Endorsed document for referral and feedback criteria for 6 provinces/6 districts	Document		X							
2.1.3. Immunization services are mainstreamed in integrated MNCH package and their coverage increased	2.1.3.1 Review district micro plans on immunization including fixed site and outreach services	PHO DHO	District plans reviewed in 6 provinces/6 districts (Aug 09)	Report		X	X	X	X	X	X	X	X
	2.1.3.2 Increase fixed site immunization where possible	MCHC (EPI) PHO, DHO	Ministerial decree (Aug 09)	Decree		X	X	X	X	X	X	X	X
	2.1.3.3 Expand provision of the Hepatitis B birth dose	DHP MCHC	Coverage	Coverage reports		X	X	X	X	X	X	X	X
	2.1.3.4 Introduce new vaccines (Hib, pneumo, rota, JE)	MCHC (EPI)	Coverage	Coverage reports	WHO UNICEF	X	X	X	X	X	X	X	X
	2.1.3.5 Immunization campaigns as needed	MCHC (EPI)	Campaign	Report of campaign	WHO UNICEF	X	X	X	X	X	X	X	X
	2.1.3.6 Ensure additional components of the integrated MNCH package are provided when mothers and babies present for immunization	MCHC PHO/PH DHO/DH HC	Monthly reports of interventions provided at immunization visits	Reports		X	X	X	X	X	X	X	X
	2.1.3.7 Ensure all health workers at health facilities providing immunization are skilled in vaccination techniques, maintaining the cold chain and able to report /treat adverse events following immunization	MCHC (EPI) PHO, DHO	Training and supervision reports	Reports		X	X	X	X	X	X	X	X
	2.1.3.8 Provide communication to mothers about benefits of immunization and other MNCH activities	PHO DHO HC				X	X	X	X	X	X	X	X
	2.1.3.9 Strengthen the vaccine preventable disease surveillance system	MCHC (EPI).			WHO	X	X	X	X	X	X	X	X
	2.1.3.10 Develop health facility capacity to respond to adverse events, including anaphylaxis	MCHC (EPI).				X	X	X	X	X	X	X	X
	2.1.3.11 Monitor the provision and installation of refrigerators and other cold chain supplies and expansion of cold chain facilities to health centres	MCHC (EPI) PHO, DHO	# of refrigerators, cold boxes, vaccine carriers, temperature monitoring devices procured, installed and distributed..	Report	UNICEF Lux-Dev	X							
	2.1.3.12 Training of health workers	MCHC (EPI)	# of health workers	Report	UNICEF								

	on cold chain maintenance and effective vaccine management.	PHO, DHO	trained on cold chain and vaccine management		Lux-Dev							
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2.1.4 The organization of outreach activities from health centres and districts is improved to reach the most remote populations	2.1.4.1 Develop protocols for outreach visits including a clear plan of villages to visit, staff to provide service, frequency of visits and service provided	MCHC	Protocols and plans developed	Protocols and plans		X	X	X	X	X	X	X
	2.1.4.2 Ensure the implementation Reach Every District (RED) strategy	PHO			WHO UNICEF	X	X	X	X	X	X	X
	2.1.4.3 Develop criteria for monitoring and evaluation of outreach activities	MCHC	Criteria developed		UNICEF UNFPA WHO	X	X					
2.1.5 Existing maternal, neonatal and child health activities are regularly reviewed and their organization is improved	2.1.5.1 Introduce emergency obstetric and neonatal care into regular monitoring and supervision	MCHC	Included in MNCH monitoring and supervision tool	Tool		X	X	X	X	X	X	X
	2.1.5.2 Ensure mothers remain in hospital for at least 24 hours after delivery for her safety and to optimize newborn survival	DOC MCHC	Ministerial decree	Decree		X	X	X	X	X	X	X
	2.1.5.3 Ensure facilities with deliveries have health workers skilled in neonatal resuscitation and SBA, or until sufficient SBAs have been trained at least 1, ideally 2 staff fully trained on MNCH package	DOC	Identify neonatal resuscitation training needs Develop training plan Training conducted	Needs assessment Training and supervision reports quarterly		X	X	X	X	X	X	X
	2.1.5.4 Orient staff and create capacity for a routine postnatal visit for mother and newborn within 3-7 days after birth	MCHC PH/ PMCH DH/DMCH	Orientation meeting				X	X	X	X	X	X
	2.1.5.5 Conduct a collaborative IMCI review with all stakeholders, identify gaps in service delivery and disseminate lessons learned	DOC, DHP MCHC	National IMCI Review workshop	Workshop report			X					
	2.1.5.6 Ensure lessons learned are used to improve or incorporate IMCI into routine services at health centre level	DOC, DHP MCHC	Plan for incorporation of lessons learned finalized	Plan			X	X	X	X	X	X
	2.1.5.7 IMCI guidelines should be updated to include recommended	DOC, DHP MCHC	Orientation meeting and Update IMCI guidelines	Updated IMCI guidelines			X					

	technical updates including neonatal IMCI											
	2.1.5.8 Introduce kangaroo mother care (KMC) for low birth weight neonates	DOC	KMC training needs assessment KMC training	Needs assessment Training report		X	X	X	X	X	X	X
	2.1.5.9. Introduce and disseminate new growth charts	DHP MCHC	Growth charts in use	Supervision reports		X	X	X	X	X	X	X
	2.1.5.10 Introduce referral system for early intervention when disability is detected	DHP MCHC DOC	Referral system for disabilities established	Routine reports								
2.1.6 Referral care for mothers, neonates and children is improved	2.1.6.1 Finalize plan for emergency triage assessment (ETAT) and treatment	DOC	National ETAT plan finalized	Plan		X						
	2.1.6.2 Implement ETAT in all hospitals through cascade training, ensuring appropriate supplies and equipment and supervision	DOC	TOT and provider courses conducted in 6 provinces/10 districts	Training report		X	X	X	X	X	X	X
	2.1.6.3 Develop plan for hospital assessments of mother, neonatal and child health services	DOC	Hospital assessment tools identified and translated, and stakeholder consultation Plan developed	Translated hospital assessment tool Plan	WHO	X						
	2.1.6.4 Conduct hospital assessments to define gaps in services	DOC	Orientation and training in hospital assessments Assessments conducted in hospitals	Training report Assessment report	WHO		X					
	2.1.6.5 Introduce hospital improvement process using quality improvement techniques based on hospital assessment findings	DOC QA & QI committee	Plans for improvements in hospitals	Plans	WHO		X	X	X	X	X	X
	2.1.6.6 Implement management of severe malnutrition in provincial and central hospitals	DOC, DHP PH,DH	Provider training in severe malnutrition Training plan for provincial and central hospitals Supervision	Training report	WHO	X	X	X	X	X	X	X
2.1.7 Wider method mix of FP services is available to respond to client needs	2.1.7.1 Ensure female sterilization is available at central, provincial and District A hospitals and at District B hospitals by provincial teams	DOC MCHC	Training needs assessment for central and provincial staff in female sterilization Training	Needs assessment Training report		X	X	X	X	X	X	X
	2.1.7.2 Ensure IUD is available at all district hospitals and selected HC with high numbers of clients	DOC MCHC				X	X	X	X	X	X	X
	2.1.7.3 Ensure male sterilization is	DOC				X	X	X	X	X	X	X

	promoted at all hospitals (central, provincial and district)	MCHC										
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	2.1.7.4 Selected FP interventions are delivered through supervised community health workers	MCHC DMCH PMCH HC			UNFPA	X	X	X	X	X	X	X
2.1.8 Health facilities are progressively upgraded to provide the integrated package of MNCH services and EmONC according to national standards	2.1.8.1 Conduct mapping of available services and requirements (infrastructure, staff, etc) to implement the MNCH package, including services for disabled children	MOH Statistics MCHC				X	X	X	X	X	X	X
	2.1.8.2 Develop plan for upgrading health facilities	PHO DHO				X	X	X	X	X	X	X
	2.1.8.3 Develop criteria to certify improvement according to standards, accreditation system	DHP MCHC				X	X	X	X	X	X	X
	2.1.8.4 Develop accreditation system	DOC MCHC					X	X	X	X	X	X
2.1.9 Standards for an adequate building with functional amenities of all health facilities are established and baby, child, mother and youth friendly services are provided by all health facilities	2.1.9.1 Develop standards for structure of health facilities including disability accessibility	DPS DOC, DHP MCHC	Standards developed and endorsed	Standards		X	X	X	X	X	X	X
	2.1.9.2 Ensure health facilities are built to standards with functional amenities (toilet, washing area), including disability accessibility	DPS DOC, DHP PHO, DHO	Facility structural and budget assessment	Report		X	X	X	X	X	X	X
	2.1.9.3 Ensure there is a budget available for necessary repairs and repairs are completed in a timely fashion	DPS, DOC, DHP	Facility structural and budget assessment	Report		X	X	X	X	X	X	X
	2.1.9.4. Ensure availability of area for sleeping and cooking in hospitals for mothers and children	DOC PHO, DHO				X	X	X	X	X	X	X
	2.1.9.5. Baby friendly hospital initiative is revitalized	DOC, DHP MCHC			UNICEF WHO	X	X	X	X	X	X	X
	2.1.9.6. Ensure privacy in the provision of MNCH services at all					X	X	X	X	X	X	X

	levels											
	2.1.9.7. Ensure informed consensus for MNCH interventions	DHP MCHC				X	X	X	X	X	X	X
Strategy 2.2: Develop sufficient and skilled Health Workforce for the provision of the MNCH integrated package												
2.2.1 Human resources needs for reaching universal coverage of the MNCH package are mapped (skilled birth attendants and additional staff for pediatric services)	2.2.1.1 Disseminate and implement the SBA plan	Department of Organization & Personnel (DOP)	See SBA Development Plan		WHO UNFPA UNICEF	X	X	X	X	X	X	X
	2.2.1.2 Estimate number of SBA needed for different levels of coverage	DOP				X	X	X	X	X	X	X
	2.2.1.3 Map additional staff needs for different levels of coverage at different levels of the health system	DOP MOH Statistics				X	X	X	X	X	X	X
	2.2.1.4 Develop HRH plan for MNCH package as part of national HRH plan	DOP MCHC				X	X	X	X	X	X	X
2.2.2 Training of human resources for implementation of the integrated MNCH package conducted	2.2.2.1 Strengthen training institutions (Nursing School, Medical School) to support the formal training of MCH Nurses	DOP MCHC	Hire consultant for stakeholder consultation Stakeholder consultation Develop curriculum for MCH Nurses	Consultation report Curriculum			X	X	X	X	X	X
	2.2.2.2 Revise the curriculum of health care providers to ensure the inclusion of the interventions of the integrated package and BEmONC in the formal training of MCH Nurses and CEmONC in the training of medical doctors and technicians of surgery	DOP DOC, DHP MCHC	Curriculum revised and inclusions incorporated	Revised curriculum			X	X	X	X	X	X
	2.2.2.3 Provide in-service training of MCH nurses in the integrated package components to improve antenatal, delivery, post-natal care and family planning	MCHC	Training	Training report			X	X	X	X	X	X
	2.2.2.4 Provide in-service training for district and dispensary staff on MNCH management	MCHC	Training course developed Training provided	Training course Training reports				X	X	X	X	X
	2.2.2.5 Provide in-service training on IMCI for health staff working in service delivery	DHP, DOC MCHC	Training in 5 core modules for MNCH package	Training reports		X	X	X	X	X	X	X

	2.2.2.6 Include IMCI technical updates in the formal training of MCH nurses, and other medical staff	DHP, DOC MCHC	Training in IMCI technical updates	Training reports			X	X	X	X	X	X	X
	2.2.2.7 Introduce a disability component in the curriculum on prevention, detection and early intervention	DOP											
	2.2.2.8 Introduce competency based training of health workers in contraceptive counselling for couples, women and men	MCHC	Develop training for health workers in contraceptive counseling Training	Training course			X	X	X	X	X	X	X
	2.2.2.9 Introduce performance based incentives to improve services for maternal, neonatal, and child health	DHP, DOC MCHC			WHO UNFPA UNICEF		X	X	X	X	X	X	X
	2.2.2.10 Ensure follow-up after training for health workers at place of work 4-6 weeks after training course completed	MCHC											

	2.2.2.11 Re-orient the role of the traditional birth attendant to provide linkages between the community and the health facility and to promote facility birth and early referral for danger signs	DHP, DOC MCHC				X	X	X	X	X	X	X	X
2.2.3 Deployment of sufficient and skilled staff for the provision of MNCH services is ensured	2.2.3.1 Develop deployment plan of staff required for MNCH services, according to national standards, needs and available resources, as part of the national HRH plan	DOP (Dept of Organisation & Personnel)		Plan			X	X	X	X	X	X	X
2.2.4 Supportive supervision and career development	2.2.4.1 Develop clear pathways within Human Resources for Health policy and strategic plan							X	X	X	X	X	X
	2.2.4.2 Provide training in supportive supervision												
	2.2.4.3 Conduct regular supervision of health staff												
2.2.5 Linkages between health facilities and communities are facilitated by MNCH staff	2.2.5.1 Regular meetings are held between health facility representatives and community representatives concerning the functioning of the health facility, timing of outreach MNCH activities	DHO				X	X	X	X	X	X	X	X

	and their content, as well as consideration of community concerns and desires												
	2.2.5.2 During outreach services an open dialogue between health service providers and users is facilitated	HC Outreach team				X	X	X	X	X	X	X	X
Strategy 2.3: Improve the management of Medical Products and Technology for MNCH services													
2.3.1 Regular supply of an essential package of drugs and other health commodities for implementation of the integrated MNCH package is ensured	2.3.1.1 Develop standard checklist and system for regular supply of medicines and commodities for family planning and maternal services (family planning kit, delivery kit, Emergency Obstetric Surgery kit, health promotion materials, basic rehabilitation equipment)	DOC MCHC	Checklist developed and endorsed	Checklist		X							
	2.3.1.2 Develop standard checklist and system for regular supply of medicines and commodities for neonatal care, IMCI and Paediatric hospital care services (including IMCI recording forms, health promotion and disability awareness materials)	DOC, DHP MCHC/	Checklist developed and endorsed	Checklist		X							
	2.3.1.3 Develop standard checklist for medicines and commodities for outreach visits	DHP MCHC	Checklist developed and endorsed	Checklist		X							
	2.3.1.4 Ensure standard set of maternal, neonatal and child health promotion materials are available at all levels of facilities	CIEH MCHC	Checklist developed and endorsed	Checklist		X							
	2.3.1.5 Develop, print and distribute standard operating procedure posters on vaccine management and cold chain maintenance	DHP MCHC	Operating procedure developed, endorsed and distributed	Posters	UNICEF	X							
	2.3.1.6 Support to the provision of annual needs of routine vaccines and EPI supplies	DHP MCHC	Vaccines and EPI supplies procured and available	Report	UNICEF Other partners	X	X	X	X	X			
	2.3.1.7 Expand the contraceptive LMIS and include data on supply and dispensing of all centrally procured MNCH commodities	MOH Statistics MCHC			UNFPA		X	X	X	X	X	X	X
	2.3.1.8. Develop standard monthly report for MNCH commodities	MCHC					X						
	2.3.1.9 Develop joint plan for MCH/FDD and definition of respective roles and responsibilities to ensure improved integration at different levels (central, provincial, district)				UNFPA	X							
	2.3.1.10 Progressively move from	?			UNFPA			X	X	X	X	X	X

	different systems to one logistics and management system											
	2.3.1.11 Include contraceptives in drug revolving fund list	FDD (Food & drug department) MCHC &				X						
	2.3.1.12 Training of provincial staff on logistics											

Strategic Objective 3: Mobilizing individuals, families and communities for maternal, neonatal and child health

Expected Result	Activities	Responsibilities	Product	Means of Verification	Lead Agency/D onor	Timeframe 2009-2015							
						9	10	11	12	13	14	15	
Strategy 3.1: Create a supportive environment for the involvement of individuals, families and communities in MNCH													
3.1.1. Through sensitization and advocacy, a supportive environment is fostered, at all levels and in all sectors of government, towards the participation of individuals, families and communities (IFC) in improving MNCH	3.1.1.1 Hold National Orientation on Working with IFC to improve MNCH, with participation from provincial and district levels		Orientation meeting conducted (Aug 09)	Meeting report		X							
	3.1.1.2 Create a multi-sectoral committee to promote collaboration on, and mobilize resources for, community-based initiatives for MNCH to meet at least quarterly		TOR developed Committee members appointed	First meeting minutes		X							
	3.1.1.3 Adopt a National Policy on Community Participation for Health		Policy developed and endorsed	Policy		X							
	3.1.1.4 Develop a plan for community participation in each district	DHO	Plan developed and endorsed	Plan		X	X	X	X	X	X	X	
	3.1.1.5 Develop a behavioural change communication strategy including hygiene, infant and young child feeding, danger signs for pregnant women, neonates and children, when to seek care and implementation of a birth preparedness and emergency plan and transport in case of emergency		Strategy developed and endorsed disseminated and community facilitators trained at central and provincial level in ToT	Strategy	WHO UNICEF UNFPA NGOs	X							
	3.1.1.6 Review existing IEC materials on maternal, child health and nutrition and based on successes develop and replicate set of materials for community program		Materials developed and produced; monitoring system for IEC materials and sufficient stock	Materials developed	WHO UNFPA UNICEF REACH NGOs	X							
	3.1.1.7 Develop training plan for LWU, CHWs and			Plan									

	TBAs and other community based individuals and groups in each district												
3.1.2 Through sensitization and capacity building, provincial and district level health workers will be enabled to work effectively with IFCs in improving MNCH	3.1.2.1 Provide training in effective counselling for MNCH to provincial, district and HC health workers (these materials to be adapted for local context from WHO Toolkit)		# of trainings held, # of participants			X							
	3.1.2.2 Develop and conduct a provincial/district training on "Promotion by Health workers of Key Family Practices for IMCI, and Community-level Integrated Case Management of Childhood Illness" and maternal health promotion including recognition of danger signs, birth preparedness and emergency plan, and transport in case of emergency and post-natal care		Provincial training kits developed; trainings provided; refreshment trainings provided			X	X	X	X	X	X	X	X
	3.1.2.3 Develop and conduct a provincial/district level Training of Trainers on "Facilitation in Working with IFCs to improve MNCH"		Training materials elaborated; # of trainings held, # of participants			X	X	X	X	X	X	X	X
	3.1.2.4 Develop and conduct training at provincial, district and health centre levels on prevention, detection and early intervention on disability		Training materials elaborated; # of trainings held, # of participants										
	3.1.2.5 Conduct Cascade Training for HC health workers		# of trainings held, # of participants				X	X	X	X	X	X	X
	3.1.2.6 Support quarterly meetings of all HC facilitators/trainers with district master trainers		#quarterly meetings; Minutes of meetings; Issues discussed at DHO				X	X	X	X	X	X	X
	3.1.2.7 Support Health Promotion Activities conducted by district and HC health workers at health facilities and during outreach		Monitoring system for promotion activities in place; behaviour change monitored; Feedback mechanism from community in place			X	X	X	X	X	X	X	X

	3.1.2.8 Establish liaison persons between community and health workers		# communities with liaison people			X	X	X	X	X	X	X
Strategy 3.2: Develop Community Participation mechanisms for better MNCH												
3.2.1 Through sensitization, capacity building and greater integration into existing health promotion efforts, IFCs will be enabled to participate effectively in improving MNCH	3.2.1.1 Meet with village leaders, members of Village Health Committee (VHC) and Lao Women's Union (LWU) and other existing community individuals and groups to orient them on the MNCH package and plan for Community Participatory Assessments (CPAs)		#orientation meetings				X	X	X	X	X	X
	3.2.1.2 Conduct CPAs at the village level to determine local priorities in MNCH and to choose village representatives to become facilitators/motivators		#of villages with CPA; #priorities identified at village level #village; representatives selected; #of CPA session per village				X	X	X	X	X	X
	3.2.1.3 Support necessary training for VHCs to address priorities as identified through CPA process											
	3.2.1.4 Where identified by CPA as priority, provide training in facilitation to village representatives											
	3.2.1.5 Support quarterly meetings of all community facilitators with district master trainers (pilot: 8 meetings annually)		#meetings per year									
	3.2.1.6 Support 6-monthly public forums/visits to HCs to improve communication and collaboration between community members and health workers (40 meetings annually for pilot)		# public forums held per year per district				X	X	X	X	X	X
	3.2.1.7 Develop mechanisms for IFC participation in data collection for M/E		#outreach sessions at each village #verbal autopsies % households with completed growth									

			registration cards										
	Develop and promote household birth and growth registration cards												
	Implement mechanism for Village Health Committee participation in investigation of maternal and infant deaths including child with disability deaths												
	3.2.1.8 Expand community based monitoring system to cover more provinces	DHP MCHC	# of villages with community based monitoring system. % of women and children using MCH and nutrition services	Report	UNICEF	X	X	X					
3.2.2 Provision of interventions and medications for mothers and children in hard to reach areas	3.2.2.1 Define which areas and villages should have medication provided by community based individuals and use existing village drug kits		% of remote villages with complete village drug kits										
	3.2.2.2 Define limited number of medications to be provided and criteria for administration		Standard operating procedures for content, use, replenishment of VDK are present										
	3.2.2.3 Orientate community based individuals and groups to provide a limited number of medications to mothers and children in hard to reach areas, ensure utilization of existing village health workers and optimize use of VDK		% of drug kits that are complete										
	3.2.2.4 Ensure that VHWs promote use of ORS for diarrhea in hard to reach areas		% of diarrhoeal episodes treated with ORS		UNICEF								
	3.2.2.5 Community based individuals and groups to provide iron tablets for pregnant women		% pregnant women receiving complete dose of Fe		WHO UNICEF								
	3.2.2.6 Promote community management of pneumonia in hard to reach areas		% of children with symptoms suggestive for pneumonia timely and properly treated		UNICEF								
	3.2.2.8 Expansion of FP provision by CBDs to northern and central		% of women of reproductive age using contraceptives;		UNFPA								

	provinces		% of VDK without sock out of contraceptives										
	3.2.2.9 Village revolving drug funds are regularly supervised and monitored, its operators timely refreshed and stocks replenished when required		#of supervision sessions; % of completely replenished VDK										
3.2.3. IFC participation in the creation of IEC materials will be expanded	3.2.3.1 Coordinate multi-sectoral database to establish extent of existing IEC materials		Database established		UNICEF								
	3.2.3.2 With community input, develop and introduce clear postings of MNCH service costs and availability at provincial/district/HC facilities		% of outreach sessions performed with all integrated services										
	3.2.3.3 Where identified through VHCs or other community mechanisms, provide support for the production of locally tailored IEC materials		% of ethnic minority villages with culturally tailored IEC materials										
3.2.4. IFC participation will be expanded in developing referral services, including finding solutions to transportation barriers that impact MNCH	3.2.4.1 Incorporate emergency and normal transport issues in the Community Participatory Assessments (CPAs)		% of villages with established emergency transport										
	3.2.4.2 Ensure integrated package of care during the outreach services that have been planned in consultation with the target communities and are executed in a timely manner		% of outreach sessions performed with all integrated services		UNICEF NGOs								
	3.2.4.3 Promote communal micro-saving initiatives to ensure availability of sufficient cash at grassroots level for paying (emergency) transport		% of villages with microfinance initiatives										

3.2.5. Multi-sectoral IFC approaches to improving	3.2.5.1 Provide peer support to pregnant and lactating		% of villages with peer support networks		UNICEF								
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	3.2.7.3 Introduce gender based data analysis in planning, M/E processes for MNCH												
	3.2.7.4 Develop activities to promote gender equality at health facility and community level to improve the response to MNCH needs and use of MNCH services												
3.2.8 Medical practices will be reviewed to accommodate women concerns and traditions (companion in childbirth, free position at delivery, fire bed, etc.)	3.2.8.1 Conduct ethnographic studies to determine culturally appropriate but medically harmless practices surrounding pregnancy, delivery, (breast)feeding and maternal and child health		# of ethnic minorities whose cultural practices have been documented through ethnographic research										
	3.2.8.2 Train health care practitioners in employing such practices and using culturally and locally appropriate language according to ethnicity of the women and children		% of health workers trained;										
	3.2.8.3 Equip health facilities are equipped to enable locally preferred practices surrounding MNCH		% of health facilities with artifacts of respective ethnic minorities										
			% of ethnic minority villages with designated liaison persons										
			% of outreach session that have report on villager's concerns										
			% of Khum meetings addressing village and other health related concerns										

Annex 2: Summary of key MNCH Issues, Gaps and Priorities

Areas	ISSUES	GAPS	PRIORITIES
MATERNAL HEALTH CARE	<p>High maternal mortality rate (405/100,000 live births)</p> <p>Very low proportion of births attended by SBA</p> <p>Very low proportion of institutional deliveries</p> <p>Low coverage of basic emergency obstetric and newborn care (BEmONC)</p> <p><i>Institutional maternal mortality or fatality due to obstetric complications?</i></p> <p>Insufficient coverage of family planning (27% unmet need)</p>	<p>Program management (including M&E)</p> <ul style="list-style-type: none"> Lack of national standards, protocols and guidelines Lower level staff not aware of some policies and guidelines MCH staff with insufficient capacity on program management at provincial and district levels Weak capacity for accurate data collection, registration and notification Weak capacity for data analysis, identification of priorities, reports writing and follow-up of health interventions Weak coordination between and within sectors in support of maternal health Lack of financial protection for the poor Different per diem and incentives used by different partners Different fees are used by different districts for same procedures 	<ul style="list-style-type: none"> Define and disseminate national standards, protocols and guidelines for the integrated package Improve MCH staff capacity on management and supervision of the quality of health services Improve data collection/registration and notification and use for program management Assure monitoring of the process indicators (ANC coverage, institutional births, PNC coverage, EmONC, Obstetric Complications, institutional maternal deaths) Create and support the functioning of a national committee on maternal and neonatal deaths Promote and support to the creation and functioning of provincial and district Committees on Maternal and neonatal deaths Establish at provincial and district level a well defined team for the implementation of the integrated MNCH-EPI package Develop mechanisms to reduce the burden of user fees Develop an uniform per diem and incentive system Revise fees system to ensure fairness
	<p>Low coverage and poor quality of antenatal care (28.5%)</p> <p>Coverage of TT in pregnant women?</p> <p>Unknown prevalence of syphilis in pregnant women - low screening and treatment rates (official data not available)</p> <p>Unclear policy routine post partum care</p> <p>Low coverage of postnatal visits</p> <p>High prevalence of anemia in women of childbearing age</p> <p>High prevalence of iron deficiency anemia</p>	<p>Health service delivery</p> <ul style="list-style-type: none"> Lack of skilled birth attendants Weak capacity of existing health care providers Insufficient availability of basic emergency obstetric care (BEmONC) and comprehensive emergency obstetric care (CEmONC) Low quality of maternal health services Missed opportunities at fixed sites Weak capacity to conduct integrated outreach activities Very limited access to health facilities for 21% of the population Referral problem between primary level health facilities and 1st level of referral (lack of transport and communication) Problems with the chain of supplying commodities (drugs, medical and materials and equipment) Limited network of Maternity Waiting Homes (MWH) Low levels of antenatal care attendance Lack of national strategy on MWH Lack of capacity to investigate Maternal Deaths and Obstetric Complications 	<ul style="list-style-type: none"> Develop a plan for skilled birth attendants Strengthen training institutions (Nursing School, Medical School), support the formal training of MCH Nurses Revise the curriculum of health care providers to ensure the inclusion of the interventions of the integrated package and BEmONC in the formal training of MCH Nurses and CEmONC in the training of medical doctors and technicians of surgery Provide in-service training of MCH nurses in the package components to improve Antenatal, Childbirth and Postnatal care and family planning Reinforce the availability of appropriate human resource at district levels Ensure regular supply of an essential package of drugs and other health commodities (kit for delivery, kit for Emergency Obstetric Surgery) Strengthen the referral system Ensure minimal requirements for the functioning of health facilities Support the implementation of national standards, protocols and guidelines Develop and approve a national strategy and plan on Maternity Waiting Homes Introduce methods to review maternal deaths and obstetric complications Conduct TT Supplementary Immunization Activities (SIA) for selected high-risk districts targeting 1,000,000 child bearing age women in 2009-2010.

	<p>Unknown burden of obstetric fistula and other major disabilities due to childbirth</p> <p>Under-utilization of maternal health services</p> <p>Cost of services, large proportion of out of pocket money</p>	<p>Individuals, families and communities</p> <ul style="list-style-type: none"> Weak linkages and limited communication between the community and health facility Lack of community mobilization and participation (men and health committees) for maternal health Lack of birth preparedness and emergency plans Lack of an updated strategy for community involvement and participation (including communication strategy) Weak coordination between Provincial and District Health Directorates and community resources implementing health interventions at the community level 	<ul style="list-style-type: none"> Advocate for health promotion and community participation Develop strategy component on health promotion for maternal health Develop National Policy on Community participation Develop a plan for community participation in each district Review existing IEC materials on maternal health, develop and replicate set of materials for community program (pamphlets, posters, posters, etc...) Involve community leaders in decisions related to maternal health Involve and train Women Union members/ establish and train health village committees (or other type of community organization) to support the implementation of maternal and neonatal health activities (particularly in assessing risk/signs of danger and implementation of a delivery plan and community transport) Develop training plan for LWU, CHWs and TBAs in each district
NEONATAL HEALTH CARE	<p>High neonatal mortality rate (26/1,000 live births)</p> <p>> 8% of population are chronic carriers for Hepatitis B , indicating high maternal to child transmission</p> <p><i>Perinatal mortality?</i></p>	<p>Program management (including M&E) The same gaps as in maternal health plus:</p> <ul style="list-style-type: none"> Lack of registration of stillbirths and neonatal deaths Weak birth registration system Weak coordination between and within sectors for neonatal health issues 	<ul style="list-style-type: none"> Improve MCH staff capacity on management and supervision of the quality of neonatal health services (maternal and pediatric services) Improve data collection/registration and notification of births and deaths (stillbirths, neonatal deaths) Ensure monitoring of process indicators related to neonatal health (ENC, EmONC, Neonatal IMCI, etc.) <p>Introduce methods to review perinatal and neonatal deaths at health facility and community level</p>
	<p>Reported cases of neonatal tetanus 17 in 2007 but surveillance data is poor therefore expect many more. 8.6 NT deaths/1,000 live births in 2001 WHO/UNICEF/MOH survey</p> <p>Under- reporting of births and deaths</p> <p>Lack of data on the institutional perinatal mortality rate</p> <p>Lack of data on institutional stillbirth with fetal heart beat+ at entrance</p> <p>Lack of data on causes of neonatal death</p> <p>Under-utilization of maternity and pediatric services</p>	<p>Health service delivery The same gaps as in maternal health, plus:</p> <ul style="list-style-type: none"> Low coverage of Essential Newborn Care services Low quality Essential Newborn Care services Lack of human resources with skills in newborn care Weak capacity to investigate Institutional Neonatal Deaths Lack of health commodities for neonatal health (Medicines, medical material and equipment) Low rate of Hepatitis B birth dose administered 	<p>The same gaps as in maternal health, plus:</p> <ul style="list-style-type: none"> Train staff on ENC, care of the sick newborn, neonatal IMCI Develop referral criteria and system to ensure proper referral and follow up of the sick/high risk newborn Ensure conditions to accommodate mothers accompanying their sick/high risk newborn Introduce kangaroo mother care Develop checklists and system for regular supply of newborn health commodities (medicines, medical material d and equipment) Expand provision and coverage of Hepatitis B birth dose
		<p>Individuals, families and communities The same gaps as in maternal health, plus:</p> <ul style="list-style-type: none"> Lack of programs and activities for the care of newborns at community level 	<p>The same priorities as in maternal health, plus:</p> <ul style="list-style-type: none"> Include newborn care in health promotion activities of Lao Women Union and other community resources Include assessment of danger/risk signs and referral in training of staff participating in outreach Promote birth registration Include verbal autopsy and data collection on stillbirths and neonatal deaths
HEALTH	<p>High infant mortality rate</p> <p>High mortality rate in children <5</p>	<p>Program management (including M&E) The same gaps as in maternal health, plus:</p> <ul style="list-style-type: none"> Weak coordination between and within sectors for child 	<p>The same priorities as in maternal health, plus:</p> <ul style="list-style-type: none"> Assure the monitoring of process indicators (IMCI, institutional child mortality)

	<p>Low exclusive breastfeeding rate (26%)</p> <p>Lack of data on causes of child death</p> <p>Lack of routine data on malnutrition</p> <p>Lack of information on disabilities</p> <p>Fatality rate due to specific diseases (Malnutrition, Measles (1-2 %), Pneumonia (20%), Diarrhea (18%) and Malaria)?</p> <p>Low coverage of children fully immunized (40%)</p> <p>High levels of malnutrition</p> <p>High proportion of stunted children</p> <p>Bed-Nets utilization</p> <p>Under-utilization of preventive services</p> <p>Under-utilization of pediatric services</p>	<p>health and nutrition</p> <ul style="list-style-type: none"> Insufficient support for IMCI 	<ul style="list-style-type: none"> Identify and implement appropriate mechanisms to review children mortality at referral health facilities and in the community
		<p>Health service delivery</p> <ul style="list-style-type: none"> Need to update national IMCI guidelines Need to scale up the implementation of IMCI Low quality of IMCI services particularly on case management Weak capacity and culture to investigate institutional infant deaths/mortality Weak capacity to conduct integrated outreach activities Problems with chain of supplying health commodities (Medicines, medical material and equipment) Referral problem between primary level health facilities and 1st referral services Lack of standards, protocols and guideline for the management of severe malnutrition RED strategy not being implemented adequately Cold chain system does not extend below district level in most areas 	<ul style="list-style-type: none"> Update IMCI guidelines In-service training on IMCI for service delivery Include new program contents about IMCI in the formal training of MCH nurses, and other medical staff Improve organization of outreach activities Develop checklist and system for regular supply of medicines, vaccines and commodities for IMCI services, immunization and micronutrient supplementation Ensure regular supply of essential package of drugs and other health commodities for IMCI services Ensure a functional referral system for illnesses of the child Assure minimal condition for the functioning of health infrastructure Develop and implement standards, protocols and guidelines to improve care of the child with severe malnutrition Ensure the implementation of RED strategy Introduce new vaccines for Hib, pneumonia and rotavirus and possibly Japanese Encephalitis in the future Expand cold chain system and ensure staff adequately maintain new equipment and fully functioning cold chain system and vaccine management at all levels Conduct follow-up measles immunization campaign for children 9-59 months in year 2011 or 2012
		<p>Individuals, families and communities</p> <ul style="list-style-type: none"> Lack of community involvement in the implementation of IMCI for the community Lack of a policy and strategy on health promotion Lack of a communication strategy for community involvement in favor of child health and nutrition Weak coordination between Provincial and District Health Directorates and NGOs implementing health interventions at the community level 	<p>The same priorities as in maternal health, plus:</p> <ul style="list-style-type: none"> Review existing IEC materials on child health and nutrition, develop and replicate set of materials for community program (pamphlets, posters, posters, etc...) Establish and train Lao Women Union, health village committees (or another type of community organization) to support to the implementation of child health activities (particularly in assessing danger/risk signs and implementation of the community IMCI, promotion of exclusive breast feeding and young infant feeding, immunization) Introduce community IMCI Expansion of community based monitoring system/tool for regular community self assessment of maternal, child health and nutrition practices.

Annex 3. Package of Maternal Neonatal and Child Health Services and addressed Outcomes

		Routine Care (Mainly Health Centres, outreach and community)	Additional Care (Mainly District Hospitals A and B)	Specialized Obstetric and Neonatal Care (Mainly Central & Provincial Hospitals)	Outcome Addressed
MATERNAL HEALTH	Non-pregnancy reproductive health care	<ul style="list-style-type: none"> • Information and counselling on reproductive health for women, couples and adolescents on lifestyle (including nutrition, injury prevention, awareness on harmful of STDs/AIDs), family planning • Provision of condoms, oral contraceptives and injectable contraceptives • Immunization • STIs/HIV risk assessment and management • Referral for unwanted pregnancy and VCCT HIV testing + safer sex • Iron and acid folic supplementation in women of childbearing age • Mebendazole 	<ul style="list-style-type: none"> • Provision of IUD • Tubal ligation and vasectomy 	<ul style="list-style-type: none"> • Management of complications and medical conditions requiring specialized care 	<p>Prevention of unwanted pregnancies</p> <p>Birth spacing</p> <p>Prevention and management of STI and HIV/AIDS</p> <p>Prevention of teenager's pregnancy</p>
	Pregnancy care 4 visits	<ul style="list-style-type: none"> • Confirmation of pregnancy • Monitoring of progress of pregnancy and assessment of maternal and fetal well-being • Detection of problems complicating pregnancy (e.g., anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy, infections) • Respond to other reported complaints • Tetanus immunization • Anaemia prevention and control (iron and folic acid supplementation) • Information and counselling on self care at home, nutrition, safer sex, exclusive breastfeeding up to 6 months, family planning, healthy lifestyle • Birth and emergency planning, advice on danger signs and emergency preparedness • Syphilis testing • STIs/HIV risk assessment and management • Promotion of insecticide treated nets (ITN) • Deworming of pregnant women • Recording and reporting 	<ul style="list-style-type: none"> • Treatment of mild to moderate pregnancy complications: <ul style="list-style-type: none"> - mild to moderate anaemia - urinary tract infection - vaginal infection • Post abortion care and family planning • Pre-referral treatment of severe complications <ul style="list-style-type: none"> - pre-eclampsia - eclampsia - bleeding - infection - complicated abortion • Support for women with special needs e.g. adolescents, women living with violence • Treatment of syphilis (woman and her partner) • Treatment of uncomplicated malaria • PMCT 	<ul style="list-style-type: none"> • Treatment of severe pregnancy complications: <ul style="list-style-type: none"> - anaemia - severe pre-eclampsia - eclampsia - bleeding - infection - other medical complications • Treatment of abortion complications • Treatment of complicated malaria • Treatment of HIV/AIDS • PMCT 	<p>Detection and treatment of pregnancy complications which could put mother and newborn at risk</p> <p>Prevention of neonatal and maternal tetanus</p>

Childbirth Care (labour, delivery and immediate postpartum)	<ul style="list-style-type: none"> • Diagnosis of labour • Monitoring progress of labour, maternal and fetal well-being with partograph • Providing supportive care and pain relief • Detection of problems and complications (e.g. malpresentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection) and referral if needed • Delivery and immediate care of the newborn baby (thermal protection, cord care, assess breathing, infection prevention and initiation of breastfeeding) • Newborn resuscitation • Active management of third stage of labour 	<ul style="list-style-type: none"> • Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction, breech presentation, episiotomy, repair of genital tears, manual removal of placenta) • Pre-referral management of serious complications (e.g. obstructed labour, fetal distress, preterm labour, severe peri- and postpartum haemorrhage) • Emergency management of complications if birth imminent • Support for the family if maternal or perinatal death 	<ul style="list-style-type: none"> • Induction and augmentation of labour • Treatment of severe complications in childbirth and in the immediate postpartum period (including caesarean section, blood transfusion and hysterectomy): <ul style="list-style-type: none"> - obstructed labour - malpresentations - eclampsia - severe infection - bleeding • ARV 	Early detection, treatment or referral of complications during labour, delivery and the immediate postpartum to prevent causes of maternal and perinatal mortality
Post natal maternal care (- first 12-24 hours after birth and - as a routine visit within 7 days with the baby)	<ul style="list-style-type: none"> • Monitoring and assessment of maternal wellbeing • Prevention and detection of complications (e.g. infections, bleeding, anaemia) • Anaemia prevention and control (iron and folic acid supplementation) • Vitamin A supplementation • Information and counselling on home self care, nutrition, safe sex, breast care, family planning, exclusive breast feeding and complementary feeding, and immunization) • Advice on danger signs, emergency preparedness and follow-up • Provision of contraceptive methods • Promotion of ITN 	<ul style="list-style-type: none"> • Treatment of mild problems (e.g. mild to moderate anaemia, mild puerperal depression) • Pre-referral treatment of severe problems (e.g. severe postpartum bleeding, puerperal sepsis) • Treatment of uncomplicated malaria 	<ul style="list-style-type: none"> • Treatment of all severe complications: <ul style="list-style-type: none"> - severe anaemia - severe postpartum bleeding - severe postpartum infections - severe postpartum depression • Female sterilization • Treatment of complicated malaria • Repair of obstetric fistula • ARV treatment and care for HIV positive women 	

NEWBORN CARE	Birth and immediate postnatal care (first 12-24 hours)	<ul style="list-style-type: none"> • Early exclusive breastfeeding (within the first hour) • Promotion, protection and support for Exclusive breastfeeding • Monitoring and assessment of wellbeing • Detection of complications (hypothermia, difficult breathing, infections, prematurity, low birthweight, injury, malformation) • Rooming-in • Eye care • Cord care • Information and counselling on home care, Exclusive breastfeeding, hygiene • Advice on danger signs, emergency preparedness and follow-up • Immunization according to the national guidelines (BCG, HepB) • Promotion of sleeping under ITN 	<ul style="list-style-type: none"> • Care if moderately preterm, low birth weight or twin baby: support for breastfeeding, warmth, frequent assessment of wellbeing and detection of complications e.g. feeding difficulty, jaundice, other perinatal problems • Kangaroo Mother Care follow-up • Treatment of mild to moderate <ul style="list-style-type: none"> - local infections (cord, skin, eye, thrush) - birth injuries • Pre-referral management of infants with severe problems: <ul style="list-style-type: none"> - very preterm babies and/or very low birth weight - severe infection - malformations - severe birth trauma/asphyxia • Supporting mother if perinatal death. 	<ul style="list-style-type: none"> • General care for the sick newborn and management of specific problems: <ul style="list-style-type: none"> - preterm birth - breathing difficulty - sepsis - severe birth trauma and asphyxia - severe jaundice - Kangaroo Mother Care (KMC) • Management of correctable malformations • Treatment of congenital syphilis • ARV and care to prevent HIV transmission • HIV testing for babies of HIV positive mothers 	<p>Minimise early neonatal complications and prevention of infection</p> <p>Reduce common causes of neonatal death</p>
	Postnatal newborn care (as routine postnatal visit within 7 days with postnatal maternal care)	<ul style="list-style-type: none"> • Assessment of infant's wellbeing and Exclusive breastfeeding • Detection of complications and responding to maternal concerns • Vaccinating children if not vaccinated early after birth (BCG and hepatitis B) • Information and counselling on home care and routine follow-up visits • Additional follow-up visits for high risk babies (e.g. preterm, after severe problems, on replacement feeding) 	<ul style="list-style-type: none"> • Management of: <ul style="list-style-type: none"> - minor to moderate problems - feeding difficulties • Pre-referral management of severe problems: <ul style="list-style-type: none"> - convulsions - inability to feed • Supporting the family if maternal or perinatal death • Additional follow-up visits for high risk babies (e.g. preterm, after severe problems, on replacement feeding) 	<ul style="list-style-type: none"> • Management of severe newborn problems: <ul style="list-style-type: none"> - sepsis - other infections - jaundice - failure to thrive - severe prematurity • Follow-up of high risk cases (e.g. HIV positive mother, malformations) 	
CARE OF INFANTS AND CHILDREN	Integrated management of sick children (IMCI)	<ul style="list-style-type: none"> • Assessing the whole child during a consultation to identify and treat all major conditions including pneumonia, diarrhoea, malaria, other febrile conditions and malnutrition • Pre referral treatment as necessary • Management of pneumonia • Management of diarrhoea - oral rehydration therapy with low-osmolarity oral rehydration salts (ORS) solution and zinc supplementation 	<ul style="list-style-type: none"> • Hospital care of the sick child 	<ul style="list-style-type: none"> • Management of other causes of childhood illness requiring specialized care • Follow-up of children with disability or chronic conditions (e.g. HIV positive mother, malformations) 	<p>Reduce common causes of neonatal and child mortality</p> <p>Prevent progression of common conditions to severe illness</p>

		<ul style="list-style-type: none"> • Management of malaria • De-worming to children of 6-59 months of age • Insecticide-treated bed-nets promotion 			
	<p>Nutrition</p> <p>Immunization</p>	<ul style="list-style-type: none"> • Exclusive breastfeeding up to 6 months of age • Continued breastfeeding up to 2 years of age • Adequate and safe complementary feeding from 6 months onwards • Micronutrient supplementation – sprinkles and Vitamin A every six months for children aged 6-59 months • Management of severe acute malnutrition (hospital and community) • Vaccinating children at the 6 weeks: DPT1, Hep-B1, and polio • Vaccinating children at the 10 weeks: DPT2, Hep-B2, and polio • Vaccinating children at the 14 weeks: DPT3, Hep-B3 and polio • Vaccinating children at the 9 months: Measles 	<ul style="list-style-type: none"> • Management of moderate malnutrition • Management of adverse reactions to immunization 	<ul style="list-style-type: none"> • Management of severe malnutrition 	<p>Improve nutritional status of infants and children</p> <p>Prevention of vaccine preventable diseases in infants and children</p>